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Nursing in New Brunswick

THE NEW BRUNSWICK Association of Registered Nurses is responsible for nursing education by an Act of the Legislature and, therefore, sets standards and makes policies for the schools of nursing. For some time, the Association has been aware that something was wrong with nursing and ways have been sought to improve the schools of nursing and thereby to render better nursing service to the people of the province.

Before any action could be taken it was necessary to know just where we stood in nursing. In order to determine this, it was felt that a survey would give us a clear picture of what was good and what not so good. Having come to this decision, the next step was to find funds to carry out a survey. A brief was presented to the provincial Department of Health and Social Services requesting a sum of money, through the federal health grants, for the purpose of conducting a survey of nursing in New Brunswick. The request for funds was granted and the study undertaken under the auspices of the Dean of Service of the University of New Brunswick. The survey was carried on for one year and the

LOIS SMITH

report released in the fall of 1956, just in time for our annual meeting.

The report of the survey, now known as the Russell Report, has been read with interest by nurses and those interested in nursing in all parts of the world. To us in New Brunswick, it has pointed out our weaknesses and strengths and the recommendations have shown very clearly just what we must do.

Immediately after receiving the report, a special committee was set up to implement the recommendations and we are happy to say that we have made some progress. Institutes have been conducted for clinical instructors, head nurses and supervisors as well as workshops and institutes for directors of nursing. Besides these, an institute for instructors in schools of nursing has been held. To carry on these extra activities, it was necessary to increase our professional staff by two: one to conduct the institutes and the other as assistant to the executive secretary. Financial assistance for the institutes was obtained from the Department of Health and Social Services. It was also necessary to increase our membership fees.

Another recommendation of the Russell Report was that a School of Nursing be established at the University of New Brunswick and this has become a reality. With a grant from the Kellogg Foundation, this school was opened in the fall of 1958 and the first students will enter with the opening of the Academic year in 1959.

Another matter which has been under consideration for many years is the place of the auxiliary nurse in organized nursing. The practical nurses of the province have requested repeatedly that we make provision for them under our Act. It was the feeling of the Association that such a group should be provided for by a public act and although we have, on more than one occasion, requested that the government make this provision we were told that this group belonged to nursing and that we should plan accordingly. In the spring of 1958, our Act was amended giving us power to draw up by-laws and regulations for the nursing assistant. Since our last annual meeting, a special committee has been busy preparing such regulations and by-laws for presentation at our next annual meeting.

I cannot close these remarks without mention of our new headquarters. In May, 1957, we moved into our new home at 231 Saunders Street, Fredericton, a large, three-story building on one-quarter acre of land. Since this building is in a residential area, it is required that someone on the staff live in the house so, our secretary agreed to occupy a part of the building. We now have office accommodations, a separate apartment for our secretary and, just recently, the third floor has been made into a beautiful conference room. We are very happy to have a building of our very own, with ample accommodation for our staff and a place for all Council, Executive and committee meetings.

These past years have been busy and productive but we must go on. The survey has shown us what we should do and, although we have made some progress, we must forge ahead with the aim of improved nursing education which will result in better nursing service to the people of New Brunswick.

LOIS O. SMITH,
President,
New Brunswick Association of Registered Nurses.

In various parts of Canada, poison control centres have been set up to supply detailed information to doctors, hospitals, or other interested persons on the poison content of many of the commercial substances that are often swallowed by children. The antidote is also supplied by the centre. This emergency aid is proving a lifesaver.

— Dept. of National Health and Welfare

The Canadian Red Cross and the American Red Cross have a mutual agreement to supply free blood to tourists who may require blood transfusions while visiting in their neighboring nation.

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The number of those who undergo the fatigue of judging for themselves is very small indeed. — RICHARD B. SHERIDAN

Rehabilitation in a Teaching Program

MYRTLE E. CRAWFORD *and* ELEANOR L. HEIEREN

GREAT INTEREST has been shown in methods of teaching rehabilitation in the basic nursing program. In order to describe how rehabilitation is included in such a teaching program it is first necessary to establish what is understood by the term "rehabilitation." It can be interpreted in a number of different ways. If several nurses were asked to define the term one would likely be given quite different definitions, depending upon the experience and philosophy of the nurse who was responding.

This article accepts, in general, a definition given in the book, "Fundamentals of Nursing" by Fuerst & Wolff[1].

> Although rehabilitation has been concerned particularly with restoring a disabled person to his best possible health, a much broader concept is becoming accepted and known today — that rehabilitation is an important aspect of all health care. It is not limited to that period of time when, for example, a patient may be helped with muscle re-education in order that he may learn new skills to enable him to regain economic and social usefulness.
>
> Rehabilitation is a continuous process and should begin with the earliest contact with the ill person. It encompasses physical, mental and social elements of care and continues throughout the period of illness and thereafter until once again the patient has become a useful member of the community.

In terms of a more restricted definition rehabilitation is a thrilling concept. In the broader outlook stated above it is an intensely challenging idea and must be one of the cornerstones of professional nursing care. The words "professional nursing care" bring up a question that is causing a great deal of distress in nursing circles and one that is giving rise to some serious soul-searching. Can we truthfully refer to nursing care as "professional" and what do we mean by it? Another question that has caused some concern is "Does the nurse really have a role in a rehabilitation program that cannot be filled by anyone else?" It is not the purpose of this discussion to go into all the pros and cons of these two questions. We raise them to have a springboard from which we can give an opinion of what makes for excellence in nursing care and how rehabilitation fits into such a type of care. This is fundamental to a consideration of how rehabilitation may be included in a teaching program.

We believe that certain types of nursing can be referred to as professional. To warrant this honorable title the broad concept of rehabilitation must be included. In other words, beginning with her first contact with an ill person the nurse has a goal, or a series of goals, which are aimed to carry the patient through the various stages of his illness until he has once again become a useful member of the community.

Rehabilitation begins with helping the patient to understand his illness and to make the necessary emotional and physical adjustments to it. It is extended to each phase of the personal care given to the patient. This care must be of such excellence that the patient is neither neglected — resulting in disability or deformity — nor overwhelmed, causing dependence and deterioration of normal capabilities. Important in this phase, also, is the ability to help the patient to a maximum degree of self-care through careful guidance and encouragement. A third aspect of care is to so plan the teaching that the patient will be able to sustain or maintain the level of health and independence that he eventually acquires as his maximum state of health. There is an important role for the nurse in each of these phases

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1. J. B. Lippincott & Co., 1956

of care, for no other member of the rehabilitation team can be so helpful to the patient in interpretation, in personal care and in teaching.

In teaching nursing arts, major emphasis is given to personal care of the patient. This is truly a nursing function and the teaching hours are weighted so that about one-half the total time of the course is spent on this aspect. Teaching the student how to administer treatments is handled as simply as possible. Groups of treatments — e.g. irrigations — are taught as a unit with the emphasis being placed on underlying principles rather than laborious repetition of steps of procedure. This streamlining allows time for a few additions that will be mentioned later.

In teaching personal care, much attention is given to the prevention of disease, deformity and disability with consideration of poor nursing techniques that might cause these things as well as specific examples of satisfactory techniques that should prevent them. For instance, in our class on decubitus ulcers we emphasize the prevention of such ulcers with only a small fraction of time being allotted to methods of caring for them. We spend time considering good posture, translating it from the erect position to various bed positions, and then discuss and demonstrate how this may be maintained in bed. Using assistance from the Department of Anesthesia, protection of the unconscious patient is taught. We also discuss ways of maintaining good body physiology through basic factors such as nutrition, exercise and elimination. Throughout the course consideration is given to emotional and psychological needs of the patient.

It was mentioned earlier that there are a few additional topics that are included. Two of these are: We ask a physiotherapist to demonstrate the deep-breathing and leg exercises used for surgical patients. The students practise these exercises. We also arrange for one of the physicians from the Department of Rehabilitation Medicine to give a few hours of specific instructions, dealing especially with the meaning of rehabilitation, where it fits into the total health picture and including also a demonstration of a few special techniques used by the department.

The question is frequently asked whether there is value in a specialized rehabilitation experience for the student nurse — that is, should a period of time be spent in a rehabilitation department? One may compare the value of such experience to that obtained from operating room experience. The average nurse is not going to be a specialist in operating room technique but she acquires an attitude towards surgical aseptic technique that is invaluable in such routine procedures as surgical dressing, catheterization and lumbar puncture. From an experience in a rehabilitation department the nurse may learn attitudes toward improvement in condition and recovery, encouragement and teamwork, consideration of the whole patient, as well as special techniques in movement and exercise.

This approach does not constitute any revolutionary change in the teaching of nursing arts, but it is a somewhat different approach from the strictly procedure-centered type of teaching that was popular ten to fifteen years ago. Concurrently with this change has developed a greater appreciation of what is considered "good" nursing care. Compare the typical private nursing given to the patient 15 years ago. The patient didn't lift a finger for days or weeks. The nurse did everything for him.

Beginning with early ambulation in surgery and obstetrics we have arrived at the kind of care being given today in which the nurse must assess the patient's strength, understanding, desire and readiness to accept responsibility for certain aspects of his own care with the additional care that he needs still being provided. This is actually, a much more difficult type of care to give, requiring more knowledge, understanding and patience on the part of the nurse. The teacher in nursing arts has had to adjust her instruction to this new form of care. She must also be careful to help the student to understand that this does not merely mean that the patient must do everything for himself but rather that in every situation this process of assessing and judging the patient's particular needs for care, encouragement and

teaching is part of his rehabilitation.

At the preliminary student level the instructor cannot develop this ability to judge in its fullest sense. In fact she probably only sees very meagre results — but if the seed has been carefully planted she can hope that subsequent teachers will nurture and develop it.

What, in general, does rehabilitation mean to the clinical instructor who functions in general surgery and medicine? When patients are being taught and encouraged to do for themselves — no matter how small the tasks may be at the beginning — then rehabilitation is in progress. From the definition given earlier it should be stressed that this process must begin early and must be continuous and progressive in order to obtain optimum results. We are using a rehabilitation approach to nursing when we assist the student on the ward to carry out the concepts that she has learned in the classroom. We help her to develop the understanding that it is necessary to allow the patient to actively participate in such aspects of his care as washing himself with assistance, feeding himself with assistance, even when the nurse could do it more quickly and neatly herself and save herself the need for changing the patient's linen, etc. We emphasize the need to practise such care.

The patient must of course also be convinced that care of this sort is good for him and must never be made to feel neglected. It is important not to confuse this type of nursing with the overly busy, shortstaffed ward situation where the patient is left to his own resources and fends for himself or does without. Although this may not always be harmful it is certainly neither as desirable nor as beneficial to the patient as planned independence.

The rehabilitation approach has been used in certain areas for some time. We think of a patient in the tuberculosis hospital. He has been taught about his disease and the limitations it will impose on him. He actively participates in his therapy. Attention is paid to his general education and to preparation for future employment and independence.

When should rehabilitation start? When we set up our nursing care plans for the patient do we not assume that every patient will recover? Is this not where rehabilitation starts? In the acute phase of the disease or injury the nurse lays the groundwork for future rehabilitation by giving adequate, intelligent care until the patient himself is able to participate actively. It is also the nurses' responsibility to recognize just when it will be advisable and beneficial to enlist the patient's active participation.

Any individual who becomes ill is a candidate for rehabilitation, regardless of the disease. It may be long- or short-term rehabilitation. Many patients return to their previous functional level but others are limited in their recovery because of permanent disability caused by the disease and not because of inadequate or improper care, for example, disability following poliomyelitis.

We have long been aware of the need to teach the diabetic patient and his relatives. We start early to educate him about his disease using suitable books, pamphlets and explanations. Long before discharge we begin his education in self-care or if he is not able his relative must be taught how to look after him. He is taught how to test his own urine, to give himself insulin under supervision, to understand the importance of proper diet, to give attention to foot care, shoes, cautious treatment of abrasions, cuts, etc. and to carry a diabetic card as well as sugar in some form wherever he goes.

Patients with congestive heart failure are taught how to use digitalis and what symptoms to watch for — to check their pulse and their weight. Other examples might include teaching patients with such conditions as phlebitis, an amputation, a gastrectomy or a radical mastectomy the important factors of their condition so that they with the help of their relatives may actively participate in the return to self-care and to their place again as useful members of the community.

The student has heard much in the classroom about the various diseases that have been mentioned here. However, no matter what her classroom background has been, in her early contact with the ward she is usually too busy looking out for herself to give much thought to anything except the

procedure she is doing. It is amazing, though, to see how quickly she learns to associate what she has learned in the classroom with the patient situation and how soon she begins to apply the concepts brought from the classroom. Judgment develops slowly and gradually. She does need much support and guidance in the management of the patient's care. This is accomplished through direct supervision by the clinical instructor, head nurse or other nursing staff. Ward conferences, clinics, nursing care plans outlined on the Kardex, the example set by the nursing service personnel, all contribute to her learning.

Our concept of good nursing care has changed much in recent years. One explanation of this change is the increase in patients using prepaid hospital plans. There are now fewer private patients paying directly for their own care. The special duty nurse who accepts remuneration directly from the patient for the service given has more difficulty managing the patient's care than the general staff nurse who accepts her salary from the hospital. So, in a sense, are hospitals also freed by the use of prepaid hospitalization. The emphasis is more on what is best for the patient and not necessarily what the patient wants or can afford.

It is a truism that when we are well we don't always want that which is best for our state of health. Thus we must be understanding with the patient who finds it difficult to cooperate. We must be patient, use gentle firmness, have controlled sympathy for the patient's predicament, be ready to stand by and encourage him and rejoice over what to us may seem to be a very small accomplishment.

In the Good Old Days

(*The Canadian Nurse* — MARCH, 1919)

Speaking to the members of an alumnae association, a Toronto doctor strongly urged them to undertake the foundation of a society devoted to preventing blindness in children from venereal disease. He advocated compulsory treatment of the eyes of all newborn babies, fines for parents who tried to prevent it and permanent recording on the child's birth certificate of the measures taken to protect the eyesight at birth.

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The Ontario legislature introduced a law requiring the physician to treat the eyes of the newborn with one per cent silver nitrate or 40 per cent argyrol. Cases of infected eyes in babies up to two weeks were to be reported to the local medical Office of Health.

* * *

About 53,000 pupils are found annually with dental defects (in Toronto). The registered attendance of the public schools is about 64,000 and that of the separate (parochial) schools about 8000.

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There can be no argument against the eight-hour day if it can be arranged to give as good service to the patient as with the longer day, and, at the same time, avoid a large expense to the hospital in a greatly increased staff of nurses.

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The question of how much sleep is necessary for the health of human beings has for long been of interest to scientists . . . A number of scientific men some time ago agreed to be forcibly kept awake for ninety hours. Only three "victims" were able to endure to the end; but, curiously enough, it was discovered that all three maintained a steady increase in weight during their time of trial.

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An article in the *British Medical Journal* denounced the practice of immobilizing injured limbs . . . Splints should not be used unless absolutely necessary, and then for as short a time as possible. Frequent passive and active movements should be carried out, steadily increasing the range.

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A concentrated solution of Epsom salts was recommended for the treatment of burns and scalds.

We Teach – Do our Patients Learn?

CHRISTINE MACARTHUR, B.S.

THE TITLE of this article contains the most important philosophy of the principles of rehabilitation: the essence of rehabilitation is good teaching.

Why do so many of us assume that teaching is synonymous with telling? Our goals in teaching patients are: to impart information; then to motivate the patient to a particular action as a result of that information. First, we must find out what the patient knows. This can only be done by effective questioning. Merely to tell a patient some facts that we have stored up is easy. To ask significant questions requires thinking and time. Learning is more a self-discovery than being told something.

One reason why we as nurses tend to avoid the question approach is that one question invites another and we are afraid we may find ourselves in deep water. If we merely tell what we know we feel safe. This is particularly true of inexperienced nurses as for instance, those who have just completed their public health nursing course. They are filled to the brim with the theory they have been acquiring all year and they can hardly wait to unload it on every patient with whom they come in contact.

However, just asking questions isn't enough. We must ask *significant* questions. If the question leads the patient to tell what he knows or how he feels it will make him think and his interest is aroused. His answer will also give the nurse some idea of his attitudes. For example, the question, "How are you going to manage brushing your teeth?" makes the patient think through the process step by step. If the nurse merely tells him how or said "Do you know how" the patient is not required to think for himself.

How many times have we said "I've told him and told him!" The patient can be told a hundred times but if he has not been motivated it is to no avail. In public health nursing we have stressed that nurses be good listeners but before anyone can be a good listener she must be a good questioner. Teaching is more than telling — it must be planned. It must be adapted to each individual's needs.

To be a good teacher in rehabilitation and to ask significant questions, we need to have a broad knowledge of the newer skills and techniques of rehabilitation. It may mean a stock-taking of the nurse's own attitudes. To *do* for a patient is almost a conditioned reflex with some nurses, who derive a great deal of satisfaction in being needed and in rendering a service which they know how to give well. To give up some of this satisfaction in favor of guiding a patient through slow, fumbling, half-hearted efforts to do something for himself is both trying and fatiguing. The nurse needs to be very secure in her skill in rehabilitation nursing to derive the same satisfaction and sense of accomplishment from her new role.

What does rehabilitation nursing mean? The word rehabilitation has become almost a by-word in present day society and there are many different interpretations depending on the interest of the individual defining it. Rehabilitation is really as old as civilization. The Bible merely said " Heal the sick." Victorian Order nurses for over 60 years have been helping sick and disabled people maintain and regain their health and usefulness.

In terms of V.O.N. care we think of rehabilitation as just good nursing care from the first day of illness until the patient completely recovers. Sometimes complete recovery is not possible and in these instances patients are assisted to live as happily and independently as possible.

Over half the branches in the Victorian Order of Nurses are in small communities where the nurse for the most part is working alone with the doctor and family. The nurses have

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always given their patients the best nursing care possible, or the best within their knowledge. However, in the past decade medical and nursing sciences have advanced tremendously and we have learned new ways to help patients back to health. This newer knowledge has been particularly applicable to patients with long-term or chronic illnesses, such as, arthritis, hemiplegia, heart conditions, fractures, diseases of the nervous system. Until recently many of these conditions resulted in crippling and a dependency on others which might have been prevented had this newer knowledge been available.

Since the Second World War there has been an increased emphasis on rehabilitation due in part to the large number of disabled veterans requiring care. Victorian Order nurses were concerned because of the increasing number of patients with long-term illnesses who were being referred for care. Many of them seemed hopeless invalids, confined to a life-time of helpless dependency. Not only the patients were discouraged, but the nurses were too, for it seemed as if their efforts to help were almost futile.

So our nurses asked for help in giving care to these people. The first request came from the Montreal staff. After several months of planning, a nursing authority was brought from New York to conduct a course on modern rehabilitation nursing. The results of this course were amazing! The principles of the course were simple and emphasized better posture and body mechanics and simple exercises. Patients responded beyond all expectations and the nurses themselves were less fatigued at the end of the day. Instead of the former feeling of inadequacy when a new patient suffering from a long-term illness was admitted, the nurses welcomed these patients as a challenging job.

But Montreal was not an isolated district and the nurses in other branches wanted and needed the same assistance in order to give their patients the advantages of these newer techniques. So again, plans were made and through the National Office a country-wide program was planned in 1953 for all Victorian Order nurses.

Not many years ago there was a fatalistic acceptance of physical disability. Many of these patients were hidden away in back bedrooms and hospitals for the incurable. To have a helplessly handicapped person become a productive human being was thought to be extremely idealistic. But with a dynamic approach to this great problem we have seen results — sometimes miraculous results.

What is the nurse's role in the rehabilitation program? Let us think for a moment of her responsibilities and how we may recognize and evaluate patients' needs in rehabilitation. First let us review the philosophy of rehabilitation. We have heard it defined as the restoration of the individual to the fullest mental, social, vocational and economic usefulness of which he is capable. Henry D. Sayer said at the 35th Annual Meeting of the International Association of Industrial Accident Boards and Commissions at St. Louis in 1949:

> Rehabilitation is not just medical treatment. It is training: it is the intelligent approach to each case as presenting its individual needs . . . It calls for leadership, the inspiration of the injured to help himself, the instilling in the injured person of confidence in himself, and a feeling that after all he has a useful place in the world. It cannot be forced on anyone . . . There are not many who do not want to improve their lot but they need guidance, encouragement and a type of leadership that has too frequently been lacking.

We know that total rehabilitation is accomplished through the combined efforts of many — doctors, nurses, physical and occupational therapists, social workers and others. We know that the needs of the whole person must be met to achieve maximum and total rehabilitation.

Nursing has a vital place in any rehabilitation program. Rehabilitation nursing must be made a part of, or integrated into all nursing care. This means that it should start as early as possible. It is not really a third phase of medical care as some people like to call it, but a continuous process carried on from the first day of illness until the patient has reached the maximum of his capabilities. It is the kind of nursing care that concentrates on

the needs of the whole person and aims to assist in restoring all sick and disabled people. It is wide in scope and comprehensive in nature; it considers the totality of patient care and it always has as its goal the restoration of the patient to a happy and meaningful life.

To practise rehabilitation, the nurse herself needs above everything else a philosophy that leads to whole-hearted belief in the rehabilitation process. It may require a complete change of attitude. Too often doctors and nurses consider chronic illness as hopeless and invalidism as inevitable. Their main interest seems to lie in the acute stage of illnesses.

All nurses need to be given a better understanding of this new approach, this change in emphasis toward illness. It is not so much on doing things for the patient as in teaching him to do things for himself.

For instance, a well meaning nurse may make a patient even more dependent than the limitations imposed on him by his disabilty. Such care can even destroy his own will to live independently. The rehabilitation attitude is a vital, life-giving one that recognizes the importance of physical independence. There are very few completely helpless patients or entirely hopeless situations.

In one of our districts a nurse was called to give care to an 80-year-old woman with a right hemiplegia of a year's duration. Her family took it for granted she would always be helpless and they did everything for her. Even her left arm and leg became almost useless through disuse. The poor woman had lost interest in living and was just wishing for death. With the doctor's permission the nurse started doing passive exercises. The patient was not very cooperative at first. The members of the family were sure all this activity would bring on another stroke, but the nurse encouraged them and explained the value of it. One day the woman was able to grasp a washcloth and wash her other hand. Gradually she got her hand to her face. A new goal was set each week. Now that she had a new interest in living, she met each visit by the nurse with anticipation. Within a few months she was able to walk. Both the patient and her family could not get over the evidences of her improvement. They regretted the fact that a whole year had been sacrificed unnecessarily.

To practise rehabilitation nursing one must understand thoroughly the contributions of other health groups in order to work effectively with them, because teamwork is the core of the rehabilitation process. As public health nurses we need to know the resources available in the community. We need to be familiar with all of the programs that are being provided to assist disabled persons. Indeed, we may even need to stimulate action in setting up programs. We need to have a close association with hospitals so that patients are referred for home care following their discharge.

In order to teach patients effectively, nurses need a body of knowledge and an aptness with nursing skills that is rehabilitative in character. What are some of these skills and how can we evaluate the total rehabilitation nursing needs of a hemiplegic patient, for example?

There are a number of areas in which we must recognize rehabilitative needs and provide the nursing skills that are required. These are:

Good nursing care with consideration for hygiene, nutrition, elimination, rest, sleep, recreation, etc.
The prevention of deformity.
The correction of deformity.
Control of incontinence.
Attention to speech problems.
Retraining in ambulation and evaluation.
Retraining the affected hand and arm.
Psychological and spiritual problems.
Self-care activities.
Family education.

We shall take it for granted that good nursing care will be provided.

The skills required to prevent deformity are those involving correct posturing by the use of positioning techniques and mechanical aids to keep the body in good alignment. Skill also is required in providing daily exercises, preventive in character and designed to keep all joints movable at their maximum range of motion.

Contracture deformities must be prevented at all costs and as early as possible. Skills in teaching self-care activities require much more knowledge and experience than many nurses have

in this area, although V.O. nurses have practised this phase of rehabilitation for years. In this respect, many patients and families have designed excellent self-care aids for use in the home. However, bed and wheel chair activities, eating, dressing, bathing, and toilet habits are definite techniques in rehabilitation that require much skill on the nurse's part if she is to incorporate them in her practise of nursing — and more important if she is going to expect her patient to benefit from her teaching.

The correction of deformities is essentially the field of the doctor and physical therapist but the nurse may work cooperatively with them and assist wherever possible.

In elevation and ambulation training the nurse has similar responsibilities. She must be skilled in crutch walking, gait-training, balancing exercises and the emotional problems inherent in these activities of daily living. She must continually guide the patient, encourage, instruct and motivate him to practise these procedures, even when they may have been initiated by someone else.

Speech rehabilitation is often one of the most difficult tasks, particularly for an inexperienced person. An understanding nurse can give a great deal of help to the patient. In many of our branches there is no speech therapist available. In such cases we have suggested to our nurses that they might get some assistance from school teachers who have remedial reading classes. To help the patient communicate in his own particular situation is the basis of all speech training. There are few things more frustrating to a person than to be unable to express himself sufficiently to be understood by others.

It was a shock to Mr. Perry, a retired accountant to awake suddenly, a paralytic invalid unable to make his simplest want known. Fear and doubt troubled his thoughts as this threatening cloud shadowed his future.

Reassurance flooded the caverns of depression as the physician explained his condition and the possiblities of rehabilitation. He told the patient the Victorian Order nurse would visit daily at home to assist him in his struggle for independence. Thus it is no longer enough that a nurse bathe a patient, see that he is clean, free from pressure sores and comfortable. She has an essential role to fill in assisting the patient to regain some measure of his former activity and to help him live with his handicap, not use it as a crutch.

On her initial visit the nurse showed that she was also a friend and adviser. Mr. Perry realized that here was a person who understood his difficulty and was eager to spur him on to victory. She explained that progress might be slow so that he would not become discouraged. She also enrolled the assistance of the family who adopted a positive attitude toward the patient's condition and showed they too were anticipating his return to a fuller life. Although he was unable to speak, the family included him in their conversation. On the advice of the nurse they refrained from speaking of his condition in his presence or referring to him in the third person. Such casual remarks could make the patient feel an "outcast," an invalid without hope.

While giving the daily care, the nurse repeated one syllable words to the patient in relation to his environment. She asked him to repeat these words when he could. Though Mr. Perry was unable to do this immediately, he observed no disappointment in his nurse and so was not discouraged. She in turn gave him easier goals, such as blowing a thin piece of paper across a mirror, so that he might feel the pleasure associated with achievement. By encouraging him to participate in his personal grooming, he slowly regained his self-confidence. When awkward movements resulted in spilled food or sent tumblers crashing to the floor, a sincere smile and the response "accidents will happen" cheered Mr. Perry to try again.

Picture his joy and that of his family when he could repeat those nouns and action verbs the nurse had continued to say, such as food, hand, sit, walk. From the day his sigh only flickered the flame of a candle to the first time he said goodbye was a long, bumpy road for this patient, but the cloud had lifted and a rainbow appeared in the sky. The patience and repeated efforts of the nurse and the family were paying dividends. If his physical progress was slow, the change in his mental attitude was profound and he was developing under-

standable speech, so important in the process of his total rehabilitation.

Occupational therapy is particularly important in the retraining of the affected hand and arm of the hemiplegic patient. It is well to teach him to make use of the paralyzed arm in every possible way. For example, in writing a letter with the uninvolved hand the patient may stabilize the writing paper with his paralyzed arm. Or in trying to feed himself, he may hold the plate in position with the paralyzed hand. The abilities that have been lost should be minimized and those that are left, stressed.

An exceedingly important thing for the nurse to remember is that most patients who have suddenly become disabled need considerable reassurance in relation to their dependency during the period of emotional turmoil when they are just beginning to realize the nature and extent of their disability. The degree of dependency is balanced between the severity of the disability and the patient's resources for developing new skills and interests. Even those patients who adjust and progress favorably may have occasional brief lapses or regressions when they need special encouragement and support.

When patients do not accept their disability we should examine our own attitude. Have we met the patient's questions truthfully and objectively? The nurse should continually remind herself that she is treating not a body, a disabled organ, or an impaired function but a fellow human being whose disability is an integral part of his total personality. The disability is not so much what the nurse thinks it is as what the patient thinks it is.

When the needs of the handicapped, hemiplegic patient are met in all these areas of care which are largely physical and emotional in nature, there still remains much to be done in preparing the patient for his return to normal living in his own home and in the community. This social rehabilitation should run concurrently with his physical and emotional rehabilitation. The family is brought into the program early so that their education may be made an integral part of the total process. This part of the program develops naturally.

What are some of the physical factors in the home that may interfere with successful home and family living? Such simple things as carpets, rugs, type of bed, the arrangement of the bedroom, width of the door for a wheelchair, bathroom facilities and arrangement, light switches, need to be considered. If the patient is a woman, adjustments in the kitchen set-up may be necessary. How will the family help the disabled one to adapt to his limitations? Will they accept him as he is, reject him or over-protect him?

What is the patient's attitude? Motivation is the keyword for rehabilitation. Unhappily, it is not something one person can simply give to another. However, the nurse is in a good position to know what incentive the patient needs to become motivated. What does he really want? What does the goal which the nurse thinks so desirable mean to him? Sometimes rehabilitation means merely being able to walk across a room or being able to feed oneself. One patient we had was an ardent gardener and his hope was that by summer he could get out to see his flowers. Another patient was looking forward to celebrating her 50th wedding anniversary that was six months away.

The education of the family should be a part of the total rehabilitation program. Every contact between nurse, patient and family should be made a learning situation with use made of every opportunity. The family needs constant help in accepting the patient's disability and in understanding his limitations, but his capabilities should always be stressed. The dangers of over-protection should be explained. They should be given a clear understanding of the progress they can expect in the patient. They should be shown how to assist him in his self-care activities. They should be helped to understand the patient's social, vocational and emotional goals so that they can work with him in attaining them. While it is the hope of rehabilitation workers that all patients will achieve total independence this is not always possible.

We believe rehabilitation is the ability to find ways and means to meet the various needs of the individual patient so that he may achieve some measure of happiness and inde-

pendence. Rehabilitation nursing requires tact, insight and an awareness of the vital role of nursing in the rehabilitation of the physically handicapped. It is a vast undertaking but if we as nurses meet the challenge we will have the immense satisfaction of seeing disabled patients learning to live again.

The Rehabilitation Team

M. LORENA MCCOLL

Coming together is a beginning;
Keeping together is progress;
Working together is success.
— HENRY FORD

SEVENTEEN-YEAR-OLD Doris had fallen and fractured her back. This is a catastrophe at any age but, when you are so young, with the usual teenager enthusiasm for an action-packed life, finding yourself with two useless legs is a tragedy. What can life possibly hold for you from now on!

Doris was introduced to hospital life from a Stryker Frame with Crutchfield tongs holding her injured spine in position — a frightening situation for anyone! Although she did not realize it at the time, her injury and its attendant complications were to involve several people representing a variety of professions and occupations — all with a single objective, her restoration to as normal a life as possible.

The people who formed the health team came from the hospital and the community. They had to be fully aware of their relationships with one another and of their common objectives:

1. To achieve maximum function for the patient's disabled body — in particular, the affected areas.
2. To maintain unaffected areas in optimum condition.
3. To assist the patient to adjust physically and emotionally to living a life within new limits but to the fullest extent of her capabilities.

Each member as it became his or her turn to participate in the program became the most important link in Doris' progress to rehabilitation.

THE PROFESSIONAL NURSE

One of Doris' earliest acquaintances was her nurse. To this member of the team fell the responsibility for creating the permissive atmosphere that would, it was hoped, secure the cooperation, respect and liking of the frightened and insecure youngster. Unless Doris could be made to feel at ease and secure in the knowledge that everyone was working towards her recovery, the efforts of the team would be in vain. You can not help the patient who does not want to be helped.

Eventual rehabilitation had to be the goal right from the time of admission. Doris had to be encouraged to help herself as much as possible as soon as her condition permitted. Her nurse initiated self-care at the earliest opportunity, gradually increasing the duties that Doris could learn to perform for herself. The nurse, in turn, had to learn to restrain her natural tendency to do things for Doris and stand aside until her assistance was essential. With each victory over a task, no matter how small, Doris' self-confidence grew.

The nurse not only participated substantially in Doris' physical care but provided the instruction and supervision necessary for those who shared this responsibility with her. She helped to coordinate the efforts of the rest of the team. In various instances, it was the nurse's observations that provided

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Miss McColl who is now assistant secretary at CNA National Office, was general convener of the nursing section of the International Northern Great Plains Conference on Rehabilitation and Special Education held at the University of Saskatchewan, Saskatoon in 1958.

the foundation upon which the next step towards rehabilitation could be taken.

In addition to her other duties, the nurse had to realize the importance of being a good listener. Doris was frightened, insecure, hostile towards the fate that had crippled her. Having gained her confidence, the nurse became Doris' confidante. Into her ears poured the story of a small child bandied about from one relative to another when she most needed a stable home; of a young girl's dreams for the future and her fears that future happiness had been destroyed by her injury. The nurse tried to foster a more optimistic outlook, to thwart tendencies toward self-pity and to build up her patient's self-esteem and self-confidence. This was a task that needed the help of others especially prepared to deal with emotional upheaval attendant upon a disabling injury.

The Psychiatrist, Psychologist and Therapists

The person who must adjust to a life limited by physical disability naturally shows considerable emotional reaction. The psychiatrist helped the nurse to understand Doris, to see how the patient's feelings would affect her behavior. He helped the patient to face the difficulties created by her injury and to accept the fact that her activities must of necessity be limited. The psychologist through the various tests at his disposal was in a position to assess the patient's capabilities and to advise on the course that her future training might follow. The various therapists — occupational, recreational, etc. — could begin while the patient was still in hospital to develop her capabilities. Her clergyman provided spiritual comfort and also assisted Doris in facing her problem and accepting it.

The Nursing Assistant

She shared with the nurse the responsibility for the patient's physical care. Doris was in need of conscientious skin care, frequent change of position, constant observation, protection against pulmonary complications and a variety of other attentions.

The nurse provided the instruction necessary to overcome any hesitancy the nursing assistant might have about caring for the patient on the Stryker Frame and with the tongs in position. She emphasized the special factor about the patient's condition that made routine nursing measures of such supreme importance — the nerve damage with the accompanying paralysis and loss of muscle function.

The assistant nurse provided valuable help in ensuring routine nursing care measures with the frequency demanded.

Medical and Surgical Care

On admission, immediate attention was focussed on Doris' injured back and the measures required to promote good bone healing. Even here, rehabilitation was the central if unspecified aim. The Stryker Frame removed obstacles to good nursing care — particularly skin care. The Crutchfield tongs helped to maintain the very necessary good body alignment.

One of the major physical and psychological problems that must be faced very early by the paraplegic patient is an incontinent bladder. Rehabilitative measures must be started as early as possible so that bladder tone can be maintained as close to normal limits as possible. A cystometrogram determined Doris' bladder capacity and an indwelling Foley catheter solved the bed-wetting problem temporarily, reducing as well the hazards to the skin. Prophylactic drug therapy was instituted to counteract possible bladder infection and forced fluids — water and nonalkalizing fruit juices — kept the urinary system functioning at maximum capacity.

Later, cystometric readings indicated that Doris might be able to develop an automatic bladder — one that will empty when a certain degree of filling has been reached. This was to be an important factor in Doris' progress since it would make a permanent indwelling catheter unnecessary. Tidal drainage was started as the first step towards this objective while she was still a bed patient.

About two and one half months after Doris' injury, spinal x-rays showed that healing was progressing most satisfactorily. She was moved to a Gatch bed with a sectional mattress

that allowed for the panning procedures required in establishing bowel and bladder control. From this, Doris soon progressed to a wheel chair.

Rehabilitative measures proceeded more rapidly now. Doris was encouraged to do everything possible for herself — bathing, feeding, turning, getting into and out of bed. The team bestowed generous amounts of praise and exercised considerable patience and self-restraint in order to give Doris the opportunity to attain her goals.

The next steps in the development of the automatic bladder were taken. The tidal drainage was discontinued. As soon as Doris reached the stage of sitting on a commode, the indwelling catheter was removed and attempts at normal voiding began. Catheterization for residual urine was done at intervals to determine how well the bladder was emptying. When the amount retained was over 60 cc., Doris was advised to apply light suprapubic pressure. Restricting fluids before bedtime helped to control the bedwetting problem. At first, the interval between each voiding was very short but as bladder capacity increased and muscle tone improved, the time intervals became longer. Doris used an alarm clock to waken herself and finally reached the stage where she was wakened once each night and could handle the problem easily during the daytime.

Paramedical Services

The occupational therapist came to the fore when Doris was able to sit up in bed and then in a chair. Shell jewellery, embroidery and similar crafts kept her busy and happy. Soon she progressed to recreational activity at wheel-chair level.

Shortly afterwards, her doctor decided that Doris should begin crutch-walking. This was to improve her general circulation and prevent calcium deposits in the kidneys and bladder. So, with instruction, assistance and encouragement from the physiotherapist, Doris began the business of learning to walk again with long leg braces and crutches.

The Hospital Auxiliary Worker

The day that Doris went on her first excursion away from the hospital was a red letter one. A member of the Ladies' Auxiliary acted as chauffeur. Both driver and passenger received full and careful instructions concerning all foreseeable situations in which they might find themselves. The venture proved so pleasant and was carried out so successfully that it was repeated several times. Doris loved being the centre of attention and her self-confidence expanded noticeably when she realized that her disability did not prohibit her from normal social activities.

The Public Health Nurse

Eventually the time came when Doris was judged fit for transfer to a vocational centre and special training. At this stage the various resource personnel in the community enter the picture, one of the first being the public health nurse.

Her contribution towards the rehabilitation of the injured person returning to the community may be summed up as follows:

1. She promotes a sane, constructive attitude within the community towards physically handicapping conditions.
2. She works jointly with all community agencies in bringing about such psychological, social and economic adjustments as may be indicated in the best interest of the physically handicapped.
3. She assists, when needed, in arranging for educational and vocational training, and in interpreting the patient's needs to parents, teachers and community.
4. She works with teachers to interpret the patient's disability and helps to plan the school program.
5. She helps the family adjust to the fact that the patient has a handicap and assists in planning as normal a life as possible.
6. She supplements medical instruction by providing the follow-up care necessary for the various aspects of patient care to be carried out in the home after discharge.
7. She encourages the patient and the family to continue medical supervision.
8. She continues to motivate the patient towards rehabilitation, realizing that it is impossible to instruct or guide

an unwilling patient, family or community.

9. She teaches the patient how to maintain good health, encourages self-care, and helps the family to exercise restraint in offering assistance.

10. She helps the patient to continue with medical instructions and avoid the complications that might otherwise develop.

We do not really know what the scope and limitations of the nurse in rehabilitation are or should be. Nursing education has traditionally been directed towards the acutely ill and further emphasis on restoring the patient as a useful, productive citizen is required.

Other Community Personnel

Once she has completed her vocational training Doris should be placed in a job where she can become self-supporting or partially so. This is the ultimate aim of the whole rehabilitation program — to make her a useful member of society.

The help of a Placement Agency may be required in obtaining employment. Society in general still requires considerable education concerning the worth of the physically disabled in business and industry. Many employers are reluctant to employ the disabled person. Education of the public is a job for all members of the health team either in the institution or in the community.

This has been the story of the restoration of one disabled person to a useful role in society. The responsibility rests not upon any one or two professions but is shared by the community resources and the institution alike. The patient too, must be made to feel that she has some responsibility for her recovery.

Rehabilitation must be the aim from the very beginning. Treating the injury alone is not sufficient. The mental, emotional and spiritual aspects must receive adequate consideration and the individual must be stimulated to live life to his fullest capabilities.

Instruction in first aid may now be given under very realistic conditions through use of the synthetic casualties developed by the Alderson Research Laboratories, Inc., New York. Moulages depicting a variety of injuries and which can be applied to the body of a living demonstrator can be obtained. These masks have been constructed so that bleeding from arteries and veins can occur which can be controlled only by proper medical methods. For classroom use or field use, a lifelike plastic model can be obtained. Hard plastic bones have been arranged to simulate fractures that can be set; wounds of every nature bleed in a natural manner. First aid personnel can now become adjusted to the shock of severe injury and emergency conditions under realistic circumstances.

Colostomy training moulages to help the patient become adjusted to his colostomy and its care in advance; a hemostasia trainer to give practice in tying off severed blood vessels and a giant oral thermometer for demonstration purposes are also available.

* * *

Experience is the name everyone gives to his mistakes. — Oscar Wilde

Very little is known about hospital equipment during the first centuries after the birth of Christ . . . Some information relative to beds is available from medieval times (A.D. 700-1500). It is interesting to note how hospitals obtained many of their beds. In France, the wealthy and the canonites (religious people) donated or willed their beds and bedclothes to hospitals. In the 16th century . . . the beds among the nobility became very rich and expansive. Elaborate bedclothes were fashioned of gold, silver and silk. In fact, bedclothes and beds became so expensive that many people who had intended to donate or will their beds to hospitals decided to give only the bedclothes and not the beds. One hospital in France, however, took the case to Parliament and in 1597 the canonites were forced to donate the entire bed with all the bedclothes, or contribute three to five hundred pounds. What had been a donation became a tax.

* * *

Overnight accommodation for wives and relatives of hospitalized patients at DVA hospitals is provided at the eight Red Cross Lodges.

The Story of Johnny

LORRAINE F. MILLER

WHAT OF THE PATIENTS who no longer need hospital care, but who still require treatment that may be given in the home? How can the visiting nurse fulfill her role on the rehabilitation team?

I am going to tell you about Johnny who had received the benefits of combined care from hospital personnel, and then was discharged to his home for continuation of treatment and rehabilitation. Johnny's physician felt that he had been in the hospital too long. His required care was such that it could be given by his mother and the visiting nurse service.

Johnny is one of a family of three boys. He is fourteen, with a mental age of nine, and had reached grade three in school before the accident that took the life of his elder brother and resulted in severe burns for Johnny. After lengthy hospitalization and extensive plastic surgery, he was ready for discharge. There was marked scarring of his upper chest, back, legs and part of his neck. Contractures of the muscles of his legs and groins had resulted in a shuffling gait.

Living conditions were only fair. The family occupied a four-room house with a bathroom in the basement. The income was low. Family relationships were a problem. The parents had rejected Johnny because he was dull. His care in the home had been and would be adequate, but love and attention were lacking. In spite of this, Johnny was glad to be going home.

Johnny's story illustrates how the health team personnel cooperated in planning for the best possible care, and how hospital services were continued in the community.

A referral was arranged by the physician, and his orders were forwarded to the visiting nurse organization. The hospital medical social worker wrote a lengthy report on Johnny, his reactions, family attitudes while he was in hospital and the immediate outlook. A home visit was made to assess the situation and see how Johnny's needs could be met. Because Johnny's exercises were so important, it was arranged for the nurse in the district to have a demonstration conference with the physiotherapist at the hospital. These two members of the team planned together for Johnny's program of physical therapy. This nurse, in turn, demonstrated to the remainder of the visiting nursing staff at a group conference. Every member was made aware of the correct method of doing the exercises.

Advice and help were given to the mother in preparing and sterilizing the small dressings still required. When sleeping arrangements were adjusted so that Johnny could have a single bed with a plywood fracture board to ensure good positioning, he came home.

The frequent tub baths posed a problem. For a short time the visiting nurse assisted but gradually Johnny's mother took over this task. The family were urged to assist Johnny only when necessary, and to make him self-sufficient. Johnny frequently attempted to use his younger brother as "picker-upper" or " toy-carrier" and this had to be discouraged.

Reports were given to the medical social worker and the physician from time to time. Attendance at clinic was stressed as necessary to Johnny's continued improvement.

Our part of Johnny's program of rehabilitation continued over a period of almost a year. During this time Johnny's mother became pregnant, and we gave prenatal advice. When his baby sister was born Johnny poured affection on her.

We endeavored to arrange for Johnny to attend Crippled Children's Camp, but although both parents consented, Johnny refused to leave home. The Salvation Army assisted in securing a bicycle for him, and the Christmas Cheer Fund provided toys at Christmas for all three children.

Miss Miller is district director with the Victorian Order of Nurses in Saskatoon.

What of Johnny's future? Physically his rehabilitation has been successful. The efforts of the hospital and community services can be said to have achieved their objective. It is not likely that Johnny will return to school. He has demonstrated a capacity for carpentry and could probably benefit from vocational classes. Under supervision and with training in those areas for which he has shown an aptitude he can ultimately become a more valuable member of the community.

Regardless of individual results and of whether we achieve complete success or have to recognize some failures — and no one can succeed all the time — this is an example of how hospital and community personnel can work together. In the hospital, in the community, the various members functioned as a rehabilitation team to take the patient to the limit of his capabilities and return him to family and to society, emotionally and physically able to enjoy life and the years ahead.

The Rehabilitation of Mrs. Moritz

DOROTHY BUTLER

THIS IS THE FOLLOW-UP account of the care given Mrs. Moritz, whose problem was discussed in the May, 1958, issue of *The Canadian Nurse*. The original article, by Miss Brenda Bauman of the Allan Memorial Institute of Psychiatry, told how the 23-year-old blond woman was admitted to the Allan for observation. There was a "lack of physical findings and a provisional diagnosis of hysterical personality." One month later, she was found to be suffering from Wilson's Disease, known as Copper Intoxication. Copper, instead of being excreted, was deposited in the basal ganglia of the brain, with resultant progressive Parkinsonism. She was treated with Penacillamine, a drug therapy for this disease only recently discovered.

This report deals with the post-hospital care of Mrs. Moritz which was provided by the Victorian Order of Nurses, Greater Montreal Branch.

The Victorian Order of Nurses, at the request of the Allan Memorial Institute, a unit of the Royal Victoria Hospital, has been providing follow-up nursing care for patients in the community on discharge from the unit or attending the day clinic. These visits provide supportive care for the patients and their families and also provide the link between the hospital and the patient in his own home. This, then, is how the Victorian Order was called into the case of Mrs. Moritz.

When she was ready to go home, the hospital arranged a predischarge conference to discuss plans for her rehabilitation. This meeting was attended by hospital personnel and the Victorian Order of Nurses. The psychiatrist reviewed Mrs. Moritz' history, her background, diagnosis on admission and diagnosis of Wilson's Disease after investigation. He outlined the symptoms and treatment of the disease which are covered in the previous article.

Mrs. Moritz was brought in and introduced to me as the nurse who would visit her at home. Her tremors gradually subsided as she grew more secure in this familiar setting. She conversed freely with hospital personnel whom she knew and talked with me about my forthcoming visits to her at home. After the patient left, I was able to ask for information and advice. The predischarge conference had proven valuable because it:

1. Enabled the patient to meet the nurse who would visit her at home.
2. Provided me with valuable background information regarding her hospitalization.
3. Brought me into contact with hospital personnel.

Miss Butler is a staff nurse with the Greater Montreal Branch of the Victorian Order of Nurses.

4. Presented an opportunity to discuss common problems of patient care.

5. Helped us discuss short- and long-term planning.

Planning is essential for all patient care but in this case, the predischarge conference was helpful in preparing Mrs. Moritz for the strict regime she must now follow for the rest of her life — any deviation from this regime would result in her becoming a helpless invalid with little hope for survival. The plan was:

1. To help Mrs. Moritz adjust from the secure hospital setting to her home, it was necessary to meet her great dependency needs, while encouraging her to become increasingly independent.

2. To supervise her medication, her fluid intake — which had to be great — and her diet.

3. To encourage Mrs. Moritz to care for herself, her family and her home. This meant helping her adjust to such a daily routine as dressing herself, eating, care of an 18-month-old child and responsibility for her household.

4. To prevent readmission to hospital by encouraging her to follow her regimen and promote independence.

5. To teach the family to encourage and support Mrs. Moritz to do everything for herself and to impress on the family that if everything was done for her, it would be detrimental to her recovery.

It is ten months since Mrs. Moritz returned to her home and I can now describe her rehabilitation. By having a well-defined plan, each visit provided additional encouragement for the patient and me. It was decided, in order for her to gain confidence, that she would be visited daily at approximately the same time and by the same nurse. The doctor had warned that although this was necessary and desirable at first, Mrs. Moritz had great dependency needs which, if fully met, would render her permanently an invalid. If we were not successful in reducing the frequency of our visits and changing the nurse, Mrs. Moritz would only be transferring her dependency needs from the hospital to us and this would not be real progress. The doctor had emphasized also that we would have to be positive in our statements to Mrs. Moritz, regarding the necessity of her becoming independent.

When I visited Mrs. Moritz, I found that the family consisted of herself, her husband, an 18-month-old adopted child and Mrs. Moritz' mother, who had come from Nova Scotia. This presented a problem because the mother had assumed complete responsibility, making it difficult for us to carry through our plan to make the patient fully independent. Added to this difficulty were the problems of poor marital relations and a strained relationship between the husband and mother-in-law. In the predischarge conference, the doctor had stressed the importance of having the mother return to Nova Scotia because of family tension. Moreover, since the husband was frequently out of town, the mother's presence encouraged Mrs. Moritz to be dependent.

I visited daily, around lunchtime, and found that Mrs. Moritz was discouraged and despondent. Her tremors were pronounced, her coordination poor. She wore pyjamas and was constantly untidy because she felt unable to dress herself. It was extremely difficult for her to manage zippers so buttoned dresses were suggested. I encouraged her and gradually she was able to dress herself prior to my arrival.

She was unable to drink as much as she needed because she could not turn on the tap. She spilled fluids and dropped glasses. I suggested that one or two large plastic pitchers of water be left by her husband and that she use straws. This enabled her to get the required fluid intake.

Her lunch was also a problem because she felt unable to light the gas stove. I suggested that sandwiches and hot soup be prepared and left in a thermos for her by her husband. These measures, I made clear, were to be considered temporary and would be discontinued as soon as her shaking was more controlled.

All the suggestions were followed and it was not too long before she was preparing her own meals. Only one project at a time was undertaken since there were so many things that Mrs. Moritz felt unable to do. She could not plug the vacuum cleaner into the wall socket so her husband did this before he left. The bedroom was small and bedmaking presented a

problem. Rearrangement of the furniture allowed her more room to move around the bed. It was necessary to help Mrs. Moritz plan a schedule of her daily activities so that she would not attempt more things than she could manage.

Wanda, the adopted child, became quite unruly on Mrs. Moritz' return from hospital. The patient often expressed feelings of physical inability to care for the youngster. But in time, and with help, she was well able to manage. Wanda contracted measles and this gave me an opportunity to teach the care of a preschool child — diet, toilet training and discipline.

Mrs. Moritz' mother accepted temporary employment in the city. Eventually, she returned to Nova Scotia with the strong desire that her daughter would come and live with her there.

Although the disease was now under control, the tremors less pronounced and the patient able to do more and more for herself she expressed a desire to return to hospital or join her mother in Nova Scotia. During the regular weekly visits to the doctor, he made it clear that it was impossible for her to go to Nova Scotia to live but that she could visit there for the summer months if she continued to improve.

This proved an incentive since the family was a closely-knit group. When she left for the summer vacation, her tremors had almost disappeared. She went to a city where there was a branch of the Victorian Order of Nurses and we referred her to them, sending a detailed summary of our service and information received from the Allan.

After Mrs. Moritz had been in Nova Scotia for two months, we received a letter from the Branch there, notifying us that she was returning to Montreal. Visits were resumed. Today, after ten months of continuous service, Mrs. Moritz has not required readmission to hospital and has been dismissed from psychiatric service. Mrs. Moritz' progress has been most encouraging; she has assumed responsibility for taking her own medication, is able to care for herself and family and, more important, is able to exercise control over her emotions. The progress made by this patient demonstrates the value of a close collaboration between the hospital and a community health agency. The Victorian Order of Nurses appreciates having had the opportunity of participating in the rehabilitation of this patient.

Remarkable progress has been made in reducing the number of new cases of blindness among children. Not only has blindness due to infectious diseases decreased sharply among school-age children, but loss of sight due to administering oxygen in high concentration to premature infants has become rare.

The most frequent causes of blindness often have their onset in middle and later life. They include specific eye conditions of unknown etiology, in particular glaucoma, cataract, and such general disorders as arteriosclerosis, high blood pressure, nephritis, and diabetes. Males have a higher blindness rate than females partly as the result of the higher incidence among males of blindness due to accidents and partly due to the earlier development of arteriosclerotic and other degenerative changes.

A study showed that half the cases of blindness could have been prevented. Early diagnosis and treatment of pathological eye conditions are the best available means to conserve sight. Periodic health checks, particularly in people past middle age, should include examination of the eyes for glaucoma and cataract, as well as for changes due to degenerative vascular diseases.

— Meropolitan Information Service.

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A compliment is something like a kiss through a veil. — Victor Hugo

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Nursing Care of the Thoracic Surgical Patient

J. A. Hinson, E. E. Oleksyn, B. Sc. *and* C. A. Dafoe, M.D., F.R.C.S.

As the number of patients undergoing thoracic surgery increases, it becomes imperative that nurses acquaint themselves with the specific nursing care involved. Recognizing this fact, the University of Alberta Hospital has organized a Thoracic and Cardiovascular Unit. Here the patients receive specialized care provided by experienced graduate nurses, and student nurses acquire knowledge and practice under close supervision. In the following article, an attempt will be made to mention various diseases encountered and to describe the pre- and postoperative nursing care as it is given and taught here.

On our unit, the most common diseases of the lungs requiring surgery are: bronchogenic carcinomas, bronchiectasis, benign tumors of the lung, lung abscesses and tuberculomas. Other operable conditions of the chest are: diaphragmatic hernias, esophageal carcinomas and diverticuli, and tumors of the mediastinum such as neurofibromas, thymomas, dermoids, etc. Surgery of the aorta and heart includes repair of aortic aneurisms, coarctation of the aorta, patent ductus and mitral stenosis.

The Cardiac Recovery Room is also located on this unit. Patients undergoing intra-cardiac surgery for congenital and acquired heart diseases with the aid of the pump oxygenator receive their care as provided by the cardiac team.*

All admissions for chest investigations to our unit receive the following tests:

Complete blood count, sedimentation rate, hemoglobin, hematocrit, Wassermann, complete urinalysis and three consecutive sputum specimens for culture and sensitivity. Chest x-rays are taken as ordered and chest physiotherapy is commenced by the therapist. Additional routine for cardiac investigations includes urea nitrogen, serum cholesterol, C reactive protein and anti-streptolysin "O" titre. An electrocardiogram, cardiac fluoroscopy and ear oximetry are usually done. Weights and blood pressures are recorded daily and specific attention is focused on digitalization, diuretics and diet for cardiac patients.

The diagnostic procedures classed as minor operations are as follows: bronchoscopies, bronchograms, esophagoscopies, left atrial pressures, cardiac catheterizations, angiocardiograms and aortograms. Breakfast is omitted for these procedures but no skin preparation is required except for an aortogram, in which case the left side of the posterior chest is shaved, if necessary. Postoperatively, the blood pressure is taken once when the patient returns to the ward, and then as often as is indicated by his condition. The patient receives nothing by mouth for one hour, then all medications and diet are resumed. Postural drainage is instituted following a bronchogram to facilitate more rapid drainage of the radio opaque dye which had been instilled into the bronchi.

When it is decided that a patient will be submitted to major surgery, he is given a high protein, high caloric diet supplemented by vitamin therapy with emphasis on ascorbic acid. In this way, the general condition is improved and postoperative healing is promoted. Two days prior to surgery a urinalysis is done and the hemoglobin, hematocrit and urea nitrogen are again checked. Blood for transfusion is ordered and is available for use in the operating theatre. Additional blood is on hand for postoperative use. Chest physiotherapy is intensified, with emphasis on teaching deep breathing and effective coughing measures to be used postoperatively. The aims of this physiotherapy are: to increase the respiratory function to its full capacity, to cleanse and main-

Dr. Dafoe and the nurse authors are cooperative members of the team working on the Thoracic and Cardiovascular Unit of the University of Alberta Hospital, Edmonton.

*Refer to "Open Heart Surgery using Total Cardio Pulmonary Bypass," *The Canadian Nurse*, August, 1958

tain a clear bronchial tree and to instruct the patient in his postoperative responsibility. Arm and leg exercises are also taught and their importance stressed.

A skin preparation is done the day prior to surgery. This includes a shave from the chin to the iliac crests, the anterior and posterior thorax, the axillae and down the arms to the elbows. The thorax is cleansed with Phisohex three times during the preoperative day. A cleansing enema is given after supper; the patient is settled comfortably for the night and an h.s. sedation given to ensure a restful night's sleep.

On the morning of operation, the preoperative sedation is given as ordered by the anesthetist. If the patient has been on digitalis, the daily dose is given preoperatively. If the surgery is being performed to correct an aortic aneurism, before the preoperative sedation is given, a Levine tube and a Foley catheter are inserted. Gentle enemas are given until the return flow is clear. These measures are taken to ensure that no undue pressure will be exerted on the graft postoperatively.

The thoracotomy unit is set up with meticulous care. The anesthetic bed is made and the following equipment is assembled and placed on the locker:

> Cellu-wipes, kidney basin, an armboard padded with soft gauze, gauze bandage, ½" and 2" adhesive tape, autoclave tape and safety pins. Also ready for use is the intravenous standard, the blood pressure apparatus and a steam kettle. The oxygen gauge and humidifier bottle are connected to the wall jet and a nasal oxygen catheter of appropriate size is attached. The wall suction apparatus is prepared for use. A nasal suction tray and a mouth care tray are also placed at the bedside.

The unit is now ready for the patient's return.

When the chest is opened at operation the state of negative intrapleural pressure is disrupted and the lung collapses. In this state it has very little, if any, function. If there are no postoperative leaks in the lung, such as may result from resection of part of it, then it is a simple matter to evacuate the air from the pleural space at the conclusion of the operation and the lung should re-expand. A constant leak of air into the pleural space will not allow re-expansion of the lung unless the air can be removed as rapidly as it accumulates. The underwater seal drainage system is used for this purpose. The positive pressure of coughing and deep respiration is probably the most effective means of removing the air from the pleural space rapidly. However this may be aided by negative pressure of minus ten to minus forty centimeters of water, produced by some form of vacuum pump, such as a Stedman pump or a thoracic thermotic suction.

When the patient returns from the anesthetic recovery room via stretcher, certain precautions must be taken in moving him to the bed. The chest drainage tube or tubes must be carefully checked to make certain that they are not taped to the stretcher and that there is no pull or tension exerted on them while the patient is being moved. The tubes must never be raised above the level of their insertion into the chest wall.

After the patient has been placed flat in bed, the dressing is inspected to see that it is intact and if any signs of hemorrhage or abnormal drainage are present. The drainage bottle is taped securely to the floor with 2" tape and calibrated autoclave tape is placed on the side of the bottle. This tape enables a fairly accurate estimation of drainage to be kept. More than 500 cc. of drainage in the first 12 hours may be considered excessive and any rapid increase in the amount of drainage demands explanation. All connections of the tubing between the patient and the underwater seal drainage bottles are taped with half inch tape to prevent air leakage and to keep the connections secure. In pinning the tube to the bed, care must be taken to ensure a continuous "downhill" run from the patient to the bottle. These drainage tubes must be "stripped" every few minutes to prevent formation of blood clots. "Stripping" is continued until the drainage is serous.

On our unit the blood pressure, pulse and respirations are checked every 15 minutes until stable, every one-half hour for two hours, then every two hours for 24 hours. Also included in our check of vital signs are: the color of the lips, ear lobes, nail beds

and peripheral "blanching" signs of the hands and feet. The patient is placed in low Fowler's position when the blood pressure is stable because this position facilitates drainage and expansion of the lungs and enables the patient to breathe more deeply and easily. If cyanosis is present, oxygen may be given nasally and continued until a good color can be maintained without its use. Anything that seriously interferes with respiratory function will cause symptoms of dyspnea and possibly cyanosis. It is important to remember that these are symptoms only and that the thing to do is discover the cause and correct it rather than to blindly administer oxygen to alleviate the symptoms.

The maintenance of a clear tracheobronchial tree by an energetic cough routine, aided when necessary by intercostal nerve block when pain is an inhibitory factor, is an important step in maintaining aeration of the lung. When the airway is not cleared by these methods, tracheal aspirations should be used. Postoperative bronchoscopy should not be delayed if these measures have failed. When the tracheobronchial tree is being flooded with secretions and tracheal aspirations have to be repeated frequently, the patient can be managed far better by a prompt tracheotomy. This is a postoperative aid that should not be held in abeyance as a last resort, but should be used more promptly. Sedation is kept at a minimum to ensure prompt cooperation in the cough routine.

A nurse is present almost continuously at the patient's bedside for 24 hours to give him constant nursing care and to be immediately aware of any change in his condition, should it occur. To encourage coughing, deep breathing and adequate drainage of air and fluid from the involved thorax, the patient is stimulated to turn from side to side hourly when awake. There is no contraindication to turning onto the operative side provided the drainage tubes are not compressed. In pulmonary surgery, early active movement, adequate and proper physiotherapy and early ambulation are potent factors in ensuring minimal complications and a speedy recovery from the disturbed pulmonary physiology and trauma.

A complete bed bath is given and the linen changed during the afternoon of the operative day. Antibiotics are given as ordered. Analgesics are administered in doses adequate to relieve pain and apprehension, but care must be taken to maintain a level of consciousness which allows for cooperation in coughing and deep breathing. Arm and leg exercises are started the evening of the operative day and the physiotherapist assists with the breathing and coughing as taught preoperatively as soon as the patient's consciousness and condition warrant it. One of the greatest measures of help a nurse can give to a patient after a thoracotomy is to regularly support his wound with her hand and encourage him to produce an effective expulsive cough. The support diminishes the pain the patient experiences with this mechanism. At a later stage, the introduction of a large folded bath towel around the chest so that the patient may grasp both ends anteriorly and exert counter pressure over the wound is a useful adjunct to produce an effective cough.

Fluids are given as tolerated if there is no nausea and diet is increased as rapidly as the patient desires. In the immediate postoperative period, one should watch for gastric distention. It is important to realize that distention, especially when marked, greatly interferes with cardiac action and decreases pulmonary ventilation. The most common finding is a rapidly rising pulse rate and eventual hyperpnea. Prompt decompression is necessary. The use of a Levine tube relieves a doubly embarrassed system. A record of the fluid intake and output is kept for at least three days. Vitamin therapy is resumed as soon as the patient is on oral intake.

The blood pressure, temperature, pulse and respirations are taken every four hours for the first two days. Then the blood pressure is checked daily, as required. The temperature, pulse and respirations are taken three times a day until discharge. A portable chest x-ray, with the patient sitting upright, is taken on the first morning postoperatively and again on the second or third days postoperatively. When the lung has re-expanded and become adherent to the chest wall, providing fistulae are not present, the drainage

tubes are removed. This state is indicated by the chest x-ray and by the failure of the column of fluid in the underwater drainage tubes to fluctuate with respiration and coughing. The tubes are removed usually on the second or third postoperative day with precautions taken to avoid letting any air into the chest by tightening a previously placed suture. The stab wounds are sealed off with an air-tight dressing for at least 48 hours. A chest aspiration may be done later to withdraw any excess fluid or air which may have accumulated after removal of drains. A hemoglobin and hematocrit check is done on the first, second and fifth days postoperatively to determine the blood balance.

To loosen bronchial secretions, steam inhalations are given for 20 minutes three times daily in addition to the continuous steam provided by the kettle at the bedside. Sputum liquifiers, such as Alevaire may be given by using an aerosal nebulizer and potassium iodide may be given orally. The use of "coughalators" and positive pressure breathing apparatus may also be employed to assist those patients who are not coughing and breathing effectively.

The patient receives a complete bed bath for the first few days postoperatively and special back and mouth care is given every two hours when the patient is awake. As his condition improves, the patient is encouraged to be up increasingly with assistance and to assume more responsibility for his own body cleanliness and oral hygiene. He is usually ambulatory within a few days after operation. The sutures are removed about seven to ten days following surgery.

Additional care required for patients who have undergone cardiac or great vessel surgery includes a restriction of fluid intake to 1000-1200 cc., for an adult, for at least two days. A record is kept of fluid intake and output for five days postoperatively. Daily weights are recorded after the patient is ambulatory, until his discharge from the hospital. The blood pressure, heart rate and regularity are recorded frequently. Again, the salt intake, digitalization and use of diuretics receive special attention. Usually ambulation is delayed in these cases as compared to patients having had pulmonary surgery.

In considering postoperative complications of thoracic surgery, it may be said that shock is somewhat more prevalent than in most operative procedures. The most effective therapy to combat shock is the replacement of the deficiency in the blood volume. For this purpose the use of whole blood is ideal and is used whenever possible. The concentrated efforts of the patient, with the assistance of the nurses and physiotherapist, in keeping the bronchial tree clear of secretions helps prevent atelectasis, which is one of the most common complications associated with thoracic surgery.

A serious complication which may arise following a pneumonectomy is a bronchopleural fistula, which is a direct communication between the bronchus and the pleural cavity. It occurs when the suture line of the bronchial stump breaks down. Should this happen while the chest drainage tube is present, it is indicated by a rapid bubbling in the underwater seal drainage bottle. If, however, it occurs after removal of the drain, it is important to establish underwater seal drainage as soon as possible, to prevent accumulation of air in the pleural cavity causing mediastinal shift, deficient heart filling and therefore lowered cardiac output and acute respiratory difficulty. The symptoms which may be present are: dyspnea, cyanosis, tachycardia, increased respiratory rate, shift of the trachea to the non-operated side and subcutaneous emphysema. The empyema which then follows may require thoracoplasty, in a pneumonectomy. The convalescence is prolonged and may be precarious.

With good care before and after operation, the course of the person who has had major thoracic surgery should be no more turbulent than that of one undergoing any other major surgical procedure. It must be remembered that a patient having thoracic, and more particularly, cardiac surgery is in a disturbed state of mind. It has been shown that the incidence of the development of temporary minor or major psychoses after cardiac surgery is much higher than after general surgery. Therefore all measures should be taken to reassure the patient, to maintain an air of confidence and to explain, in simple lay terms, the object

of the surgical procedure; what it will accomplish and what he can expect postoperatively, always maintaining a positive and optimistic outlook. Advances in surgical technique and anesthesia have played a major part in the success of thoracic surgery, but the results are as much dependent upon intelligent and enlightened nursing care as on any other factor. If the few simple principles stated here are kept in mind, the thoracic surgical nurse will find that "All things are clear in the light of reason."

Skin Antisepsis

PHILIP B. PRICE, M.D.

A HIDDEN RESERVOIR of bacteria exists somewhere deep in the human skin. The precise location and quantity of these "deep bacteria" are as yet unknown but appreciable numbers of them begin to appear in washings of the skin after 10 to 15 minutes of scrubbing. This strengthens the theory that it is impossible to kill or remove all germs in the skin without destroying the skin itself.

Both "transient" and "resident" germs are found on the surface of our bodies. "Transients" vary tremendously in number and in kind. Fortunately for the health of man, most of the extraneous microorganisms that get on his skin soon disappear. Some die; others fall off, are rubbed off on clothes or are washed off. In general, transient bacteria are more abundant on exposed skin, but enormous numbers of them collect under the nails, between the toes or wherever there is protection. It takes from one to eight minutes of washing with soap and water to remove all transients from the hands and arms. They can be killed with relative ease by chemical disinfectants.

"Residents" form the stable bacterial population of the skin. They live, multiply and die there. Inasmuch as resident bacteria are firmly attached to the cutaneous surface, washing removes them slowly. They are less susceptible than transients to the action of disinfectants. Residents are composed largely of staphylococci of low pathogenicity, but a few Staphylococcus *aureus* and other pathogenic bacteria are almost always present.

The primary purpose of a skin disinfectant is to reduce effectively these bacterial populations. Other things are important — nontoxicity, stability, ease of application, inexpensiveness — but the prime requisite is disinfection of the skin.

Various tests are used to evaluate disinfectants. The serial basin handwashing test is the only test of skin disinfectant action that reproduces faithfully the conditions of actual use, that is capable of controlling all the variables, that eliminates with certainty the troublesome factor of bacteriostasis and measures the effect of disinfectants on the skin flora, quantitatively and qualitatively, with a fair degree of accuracy. The status of some common skin disinfectants follows:

Ethyl Alcohol — For routine surgical use, 70% alcohol by weight is recommended for several reasons. It is somewhat less expensive than the more concentrated preparations. It wets the skin well, spreads smoothly, and evaporates slowly. It does not injure the keratin or extract the lipids of the epidermis, and in consequence is almost perfectly innocuous on the skin.

Isopropyl Alcohol — It might well be substituted for ethyl alcohol in prepaparations used to disinfect the field of operation, but it is not recommended

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Dr. Price, who is Dean of the University of Utah College of Medicine, delivered an address on this subject as part of a series of lectures sponsored by Becton, Dickinson and Company and Seton Hall College of Medicine and Dentistry, Jersey City, N.J.

for routine preoperative preparation of the hands.

Mercurials — The best of these solutions has been found to reduce the flora by less than half in three minutes but in general they are not easy to evaluate accurately or with assurance.

Iodine — One or two per cent iodine dissolved in 70% alcohol is an excellent skin disinfectant. It spreads evenly, dries slowly, and evaporation does not leave a rim of concentrated iodine to burn the skin. Aqueous solutions of iodine should not be used on the skin, since they may cause severe burn and even iodism from absorption.

Zephiran (Benzalkonium Chloride) — In vitro, zephiran is a powerful, rapidly acting germicide against test bacteria, but on the skin, under conditions of ordinary use, its disinfectant action is not as great as has been generally supposed. Hands and arms that have been scrubbed in the usual manner need to be very thoroughly rinsed with water (for one minute or more) in order to remove the soap which clings so tenaciously to skin and tends to neutralize the bactericidal action of zephiran. Since solutions of alcohol are better soap solvents than water, it is recommended that the site of operation be washed alternately, several times, with 70% alcohol and tincture of zephiran.

G-11 (Hexachlorophene) — It has been asserted that persons who operate regularly no longer need to scrub in the old-fashioned manner, nor soak their hands in disinfectant solution. Instead it is necessary only to lather their hands and arms for two or three minutes with G-11 detergent. As far as I can determine, single periods of washing or scrubbing for from one to ten minutes with preparations of G-11 in bar soap, liquid soap, or Phisoderm, do not immediately reduce the cutaneous flora any more rapidly than if the washing had been done with Ivory soap. Used rationally and faithfully, G-11 soap of G-11 Phisoderm is probably capable of contributing materially to the perfection of aseptic surgical technique. In my judgment it should not be employed to the exclusion of the conventional preoperative scrub or the customary chemical disinfection of hands and the field of operation. It seems to me that danger lies in the creation of an unwarranted sense of security in the minds of those who choose to believe that a single, short, timesaving wash with a G-11 detergent can be depended upon to disinfect the skin.

Red Cross Fellowship

FOR THE PROFESSIONAL NURSE who is prepared to undertake special graduate study in a specific field such as research, general education, social work or hospital architecture, assistance is now available.

The qualifications of candidates should include professional maturity, registration in Canada, a baccalaureate degree and professional experience covering a period of not less than five years. Preferably, the preparation sought should be for a specific position available and accepted by the candidate.

The amount of the bursary will be related to the needs of the candidate. It is hoped that an annual grant can be added to the fund and that the total amount accruing will be the limiting factor in relation to the degree of support, the length of study and the frequency of the award.

Enquiries should be directed at an early date to the **National Director of Nursing Services, Canadian Red Cross Society, 95 Wellesley St. E., Toronto.**

* * *

The little fisherman on our cover picture is Philip Little, the 1959 National Easter Seal Child for the United States. The annual campaign here began on February 27 and will continue until March 29. The funds from the sale of seals will ensure continuing care for children crippled by cerebral palsy, poliomyelitis, accidental injury and other conditions. Programs of research and study will give each child a better opportunity for successful rehabilitation.

RESEARCH

The Need for Research in Nursing

NETTIE D. FIDLER, B.A.

A PROFESSION AND ITS HALLMARKS

PROFESSIONS have as their primary objective service to man and society. For this purpose they are measured by certain criteria which are applicable to them all. There is, of course, the application of their knowledge in services which are vital to human and social welfare. They attract individuals who place service above personal gain and who regard their occupation as a life work. In these ethical and social fields it appears that nursing is acknowledged to be professional. In fact it has been said that no other professional group has a higher concern for the welfare of its clients.

There are, however, certain other criteria. A profession bases its practice on a well-defined and extensive body of knowledge on the level of higher learning. Closely related to this, it constantly enlarges this body of knowledge by the use of the scientific method. In other words it grows in competence by research.

Nursing has very good friends in other professions. All seem to regard nursing as essential; all try to make constructive suggestions; all point out the need for research, but all question the body of knowledge, especially in science. We have all read recently the work of Esther Lucile Brown, of Margaret Bridgman, of the Ginsberg Committee. I would like to go back a little and quote from another person interested in nursing, writing exactly 20 years ago. Dr. H. B. Atlee of Dalhousie University says:

> It seems to me that if your profession is to inherit the place in the medical sun which it deserves it must somehow enhance its prestige . . . Faced by the alternatives of either struggling for improvement within your present limitations or setting yourself a new goal, I believe you must choose the latter . . . (By this I mean) that you should become more professionalized . . . As I see it, a profession is a group of trained workers which has within itself the capacity for making a more and more specialized contribution to human welfare . . . The professional worker creates his own world. The worker in a shoe factory is given a shoe to make, of which the pattern is very clearly laid down. But the doctor is given a sick body to deal with and in the handling of the problem he creates a whole new world of anatomy, physiology, physical and mental therapy, and prevention. On the basis of that definition I do not think it can be truly said that nursing is yet a real profession. Too much of the pattern you follow has been imposed on you from without — from my own profession, for instance —

Miss Fidler, who is the director of the School of Nursing, University of Toronto, prepared this article as the first in a series to be devoted to the subject of research in nursing.

and not enough is created within yours. So the goal I would like to see you set yourselves is one towards which you will move more and more through your own initiative and resource.

. . . I see no reason why the nurses of the future should not carry out nursing research. If my profession is given facilities for the purpose why should yours be denied them? The only rational basis of denial would be that there is no longer room for improvement in nursing — which is ridiculous.

He goes on to say that nurses will have difficulties in gaining these facilities — difficulties created within their own ranks and from the medical profession. ". . . I and my confreres will maintain stoutly our right to the sole overlordship of the medical world."

The Problems of Nursing

We have seen that friendly critics urge research as necessary to a profession and to professional prestige. The real purpose of this is to improve nursing — to find answers to the unsolved problems which have been multiplying ever more rapidly in recent years. Examples of these problems are: the form or forms that nursing education should take; the best use of the nurse's time and skill in the hospital and public health fields; the use of the nursing team; relationships with other health professions; the formulation of a nursing science; and above all the direct nursing of patients.

These are examples taken at random. Some of them are so large that they would need to be divided for study. The profession is aware of these problems, and in Canada (as in Britain and the United States) there have been the beginnings of research on them. In this country we may cite the study which led to the reorganization of the Canadian Nurses' Association; the Canadian Nurses' Association's demonstration school of nursing at Windsor, Ontario; the study of nursing education in New Brunswick; the study of the functions and activities of head nurses made by the Research Division of the Department of National Health and Welfare in cooperation with the Canadian Nurses' Association; and the cost study of basic nursing education programs in Saskatchewan.

Participation in Research

Although all nurses cannot and will not carry on major research projects, we all need to have a clear idea of the research process, of the "research approach," and of the basic concepts of statistics because:

1. We are all consumers of research and of statistics. We should be able to understand and evaluate the research of others.

2. Many nurses, not primarily interested in research, have immediate concrete problems of nursing, of administration or of education which have to be solved today. The regular steps used in research are applicable to any such problem and will provide the best solution.

3. This understanding is also useful in the assistance in medical research projects for which nurses are sometimes asked.

The Role of the University in Research

The functions of the university are often described briefly as teaching and research. All teachers must do research in connection with their teaching if it is not to become static. Some give a large part of their time to research. The undergraduate student does not do research in the full sense of the word. Nevertheless, it is in the undergraduate program that the foundations are laid for the research he may undertake later as a graduate.

It has always been accepted that one of the results — perhaps the chief result — of a university education should be a "trained mind." It is assumed that thinking ability is actually improved and increased. This "training" is not simply a matter of furnishing the mind with existing knowledge, important though this is. It is above all not a rigid conditioning to the past and to conservatism. The result desired is a disciplined and free mind. The subjects are liberalizing in themselves, but liberal teaching is necessary for their full effect. Thus the spirit of curiosity and inquiry should be given free rein from the beginning, while gradually the student's thinking becomes more responsible and more subjected to the test of evidence and to

logical ordering — in short, a research attitude is developed.

This type of teaching and learning is not confined to universities. It can be, and indeed it is, used by good teachers in every type of professional or academic school. This is desirable from every point of view. In relation to the promotion of research in nursing it is essential, for our greatest obstacle is lack of trained personnel. This obstacle will not be removed until schools offering the basic nursing program liberalize their teaching so as to inspire and enable many students to proceed at least to their bachelor's degree, which is now generally recognized as the basic qualification for a research worker.

The training of the research worker is, of course, the direct problem of the university schools of nursing and will require great effort on their part. The universities cannot lower the standards of their graduate degrees to accommodate nursing, nor would this be desirable. If nursing is to progress as a profession its degrees must be comparable academically with the best degrees in any field. Our greatest difficulty is to find staff members with broad liberal backgrounds and with graduate degrees who are capable of building up the teaching and research programs of our schools to true graduate level.

Our second problem is to begin research programs here and now with such staff and facilities as we have at present in order to create a field into which students may be introduced. The solution of both these problems is dependent, to a large extent, upon our ability to interpret our needs to the administrators of our universities.

If this task of interpretation is to be accomplished, the profession must be united with us in its desire for graduate programs that would make research in nursing possible. The Canadian Conference on Nursing, convened by the Canadian Nurses' Association in 1957, went on record as urging the need for graduate work. Do nurses as a whole agree with them? Can we assert confidently that the great majority of practising nurses think this matter urgent because they find that they need the kind of research which the university should provide?

We know that the idea of nursing research is young, but certainly there seems to be much interest and discussion of it now. In our own small efforts at the University of Toronto we have not found the attitudes which Dr. Atlee feared. We have had unstinted cooperation and collaboration from the nurses whose fields are involved. This did not really surprise us, though we knew they were very busy. What has surprised us, I think, is the interest shown by the doctors in these fields. We saw no sign of a desire to retain "the sole overlordship of the medical world."

And so, though there are many obstacles and difficulties in the way, I cannot but feel that if we truly want research in nursing we will have it. For, to return to Dr. Atlee: "It is an historical fact that in preparing himself for a better future, mankind has invariably created that future."

Alumni of Teachers College, Columbia University, will attend a celebration late this spring commemorating the 100th anniversary of the birth of M. Adelaide Nutting, nursing education pioneer, and the 60th anniversary of the founding of the college's Division of Nursing Education. The celebration will be held May 15 and 16, 1959.

There will be a dinner on the night of May 15. On May 16, an all-day meeting will be held at Teachers College. The meeting will focus on Miss Nutting's leadership in setting the foundation for nursing education in the United States and abroad, and on the future of nursing education.

* * *

Over 800 registered nurses serve as volunteer instructors of the Canadian Red Cross Home Nursing Courses in communities throughout the nation.

* * *

The aim of reading . . . is gradually to create an ideal life, a sort of secret, precious life, a refuge, a solace, an eternal source of inspiration in the soul of the reader. — ARNOLD BENNETT

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Une Fructueuse Pratique

Soeur Mance Décary

L'ASSEMBLÉE ANNUELLE du nursing est la réunion de tout le personnel professionnel du nursing et ses invités qui sont les autorités de l'Hôpital, les médecins, les internes, les chefs de service des départements auxiliaires et de représentantes de l'Association des Infirmières de la Province de Québec.

Le but de cette réunion annuelle est d'informer chacune du travail accompli dans les différentes sections du département du nursing au point de vue du service des malades et de l'éducation, de faire des recommandations et de procéder à l'élection des membres des différents comités du nursing.

L'idée de convoquer une assemblée annuelle du nursing à l'Hôpital Notre-Dame est venue à la suite de l'organisation scientifique du service du nursing qui date de 1951. Le service du nursing suit un plan d'organisation bien défini qui est expliqué par un diagramme précis. L'évaluation du personnel nécessaire, tant professionnel qu'auxiliaire, pour assurer des bons soins aux malades est basée sur les heures de nursing requises par jour. Ce calcul est possible grâce à la feuille de répartition du travail que les responsables des départements complètent pour une période de 24 heures, une fois la semaine, et qu'elles versent ensuite au secrétariat du nursing où la compilation est faite. Afin de faciliter le travail et de le standardiser tout en améliorant constamment le soin des malades, nous avons préparé:

1. *Le manuel du service du nursing,* instrument de travail qui présente les notions essentielles de l'organisation de ce service dans le but d'instruire le personnel de ses obligations et de lui faciliter l'observance des règlements de l'hôpital. Ce manuel traite des attributions du personnel, des conditions de travail et des directives au personnel, directives concernant les malades.

2. Le cahier de relations inter-départementales qui explique toutes les formules employées dans l'hôpital et la façon de procéder pour obtenir un service des autres départements.

3. Le manuel de techniques en nursing revisé chaque année.

4. Un système de dossier permanent pour chacune des infirmières à l'emploi de l'hôpital.

5. Un inventaire perpétuel du matériel, préparé et revisé tous les mois d'une façon plus ou moins élaborée.

6. Un budget quant aux item "salaires" et "matériel" alloué pour le nursing.

7. Les comités suivants ont été formés et fonctionnent effectivement:

Le Comité Exécutif du Nursing, le Comité de Régie de l'Ecole, le Comité Conjoint du Nursing, le Comité du Nursing et de la Pharmacie, le Comité d'Admission des Elèves à l'Ecole, le Comité d'Admission aux Cours Post-Scolaires, le Comité du Curriculum, le Comité de la Recherche en Nursing, le Comité d'Organisation du Travail d'Equipe, le Comité du Service Privé, le Comité d'Etudes des Techniques Théoriques et Pratiques.

8. Des assemblées fréquentes avec les hospitalières servent de moyen de communication entre tous les membres professionnels et auxiliaires de notre service.

9. Un programme éducationnel a été élaboré. Il se divise en trois parties: orientation, enseignement sur place, enseignement continu.

Après avoir établi toutes ces bases, nous avons pensé que l'évolution du nursing devait être soulignée car malheureusement, beaucoup trop souvent, on ignore ce qui se déroule dans une institution de l'ampleur de la nôtre. Nous avons cru que les autorités de l'hôpital et les infirmières seraient intéressées à prendre connaissance de tout le travail qui se fait dans les différents départements du nursing, de même que des statistiques assez complètes que nous étions en mesure de présenter.

C'est alors que nous avons tenté d'inaugurer en 1953, notre première assemblée annuelle du nursing sous la présidence d'honneur conjointe de

Soeur Décary est la directrice du nursing à l'Hôpital Notre-Dame, Montréal.

Soeur Denise Lefebvre, directrice de l'Institut Marguerite d'Youville, et de Mlle Suzanne Giroux, visiteuse officielle des écoles d'infirmières.

Les rapports présentés à cette assemblée par les Religieuses et infirmières responsables des départements sont les suivants:

Section de l'Education, Section des Activités Scolaires, Service des Malades: éducation, personnel, organisation, rapports du service de nuit, salles d'opérations et de réveil, oxygénothérapie, cliniques externes, deux ou trois rapports des différents services des départements des malades.

Afin de souligner l'importance du travail en comités et le résultat obtenu, la lecture est faite des rapports des comités:

Comité du curriculum, des techniques théoriques et pratiques, du service privé et du comité Conjoint du Nursing, etc.

A l'issue de cette première assemblée annuelle, les infirmières ont manifesté un tel enthousiasme à la révélation du travail effectué dans le service du nursing depuis son organisation, qu'elles ont manifesté le désir qu'une réunion semblable soit tenue annuellement.

Cette recommandation a été suivie et depuis, chaque année, nous avons eu des assemblées similaires sous la présidence d'honneur de différentes personnalités. Après chacune de ces assemblées, tous les rapports sont imprimés et adressés aux administrateurs de l'hôpital, aux chefs des services, aux médecins qui sont membres du Comité Conjoint du Nursing, et aux infirmières à titre d'information et de références, particulièrement pour les personnes qui n'ont pu assister à l'assemblée à cause de leurs heures de service.

ENGLISH OR FRENCH?

Everyone is aware by now of the fact that two separate issues of our *Journal* will be published each month commencing with the June, 1959 number. This important milestone in the history of the nursing profession in Canada will be marked by several changes. A smart new cover design for both issues has been approved. We are departing from the dark blue color on the cover that has identified our *Journal* for the past 20 years.

Arrangements have been made respecting publication dates. *The Canadian Nurse,* as the senior issue, takes precedence. It will come from the press at the beginning of the month. *L'Infirmière Canadienne* will follow in approximately ten days.

Currently, the separate mailing list for those who desire to receive the French issue is being built up. The A.N.P.Q. is helping us very materially by indicating with an asterisk those of its members who are English and who will, therefore, be put on the mailing list for *The Canadian Nurse.* All other subscribers in the province of Quebec will automatically be placed on the list of those who will receive the French issue. Any among the latter group who wish to receive the English issue instead are requested to notify the Journal office in writing before *April 15, 1959.* Please give us your registration number as well as your full name and address to avoid the possibility of errors.

Similarly, *L'Infirmière Canadienne* will be available to any subscriber who wishes to receive the Journal in French. All that will be necessary is to notify us in writing, again giving the essential information for identification purposes: Your name, address, province of registration and registration number.

Of course, changes can be made later at any time. But every nurse who wishes to make a change in the above-mentioned listing must notify us by **April 15, 1959** if she wishes to receive the June issue.

Such changes will only be made when they are requested in writing. The address to which all of these letters should be sent is:
The Canadian Nurse Journal,
1522 Sherbrooke Street West,
Montreal 25, Quebec.

I enjoy convalescence. It is the part that makes the illness worth while.

— G. B. SHAW

Nursing Profiles

As the federal government plan for hospitalization is accepted and set up in the various provinces, a pattern is evolving whereby a nurse consultant is appointed by the individual Hospital Services Commission. In New Brunswick **Doris M. Grieve** has been selected to fill this position.

DORIS GRIEVE

Born in New Brunswick, Miss Grieve received her early education there and later attended the Normal School (now Teachers' College) in Fredericton. After teaching school for a number of years her interest turned to nursing. She is a graduate of Ottawa Civic Hospital and has had postgraduate preparation in teaching and supervision at McGill School for Graduate Nurses. Miss Grieve has had considerable experience in administration in the fields of nursing service and nursing education. Until accepting her present appointment she was in charge of the nursing education program of Saint John General Hospital.

Dorothy A. Potts was appointed the second nursing adviser to the WHO Regional Director of the Eastern Mediterranean Region late last year and has taken up her new duties in Alexandria, Egypt.

A graduate of Moose Jaw General Hospital, Miss Potts secured her baccalaureate degree in nursing before joining the staff of Toronto General Hospital where she held the position of surgical supervisor 1947-1949. She resigned to become the director of nursing at Belleville General Hospital where she remained until joining WHO in 1952. Her first assignment was to Dacca, East Pakistan as leader of a team of three nurses concerned with the development of a basic school of nursing. In 1957 Miss Potts was granted leave of absence to take advantage of a Kellogg Fellowship award and further study. She obtained her Master's degree in consultation in public health during this time.

Immediately prior to her present assignment Miss Potts was in Singapore where WHO has been assisting with the improvement of nursing services — nursing education, midwifery and public health. She was responsible for planning and conducting programs in ward administration and clinical teaching. As opportunities arose she also participated in programs for hospital matrons or directors of nursing service. In her present capacity she will undertake the responsibility of giving technical advice for the planning and coordination of the regional nursing program of WHO. She will advise and assist national health administrations with the development of their nursing and midwifery services and selection and training of personnel. She will also participate in nursing studies as a basis for long-range planning.

The announcement of the appointment of

SISTER CATHERINE GERARD

Sister Catherine Gerard as a member of the Royal Society of Health, London, England was received recently. This honor was bestowed upon her by reason of her contribution to nursing education and hospital administration and her colleagues and friends in nursing will agree that it is well deserved recognition.

A graduate of Hamilton Memorial Hospital, now St. Elizabeth Hospital, North Sydney, N.S. she studied at Saint Louis University, Missouri to obtain her certificate in hospital administration. Beginning her association with Halifax Infirmary as a general staff nurse, her administrative ability was soon recognized and Sister Gerard assumed positions of progressive responsibility. She is now the administrator of Halifax Infirmary.

This fall the university of New Brunswick will open the doors of its new school of nursing. **Ryllys Mae Cutler** has been appointed assistant professor and consultant in psychiatric nursing.

A graduate of Royal Victoria Hospital, Montreal, Miss Cutler also holds her degree in nursing from McGill University and has had extensive preparation and experience in

(Rice, Montreal)

RYLLYS M. CUTLER

psychiatric nursing at the Provincial Mental Hospital, Essondale, B.C. For the past year she has been a member of the NBARN provincial office staff and has had the responsibility of conducting various nursing institutes and follow-up programs.

Late last fall **Gertrude Dallaire** was appointed chief nurse with the City Health Department, Montreal. A native of Quebec, she

(Garcia Studio—Montreal)

GERTRUDE DALLAIRE

is a graduate of St. Justine's Hospital, class of 1933.

After spending several months in the medico-social department of her home hospital, she joined the staff of the Montreal Children's Hospital in 1935 and during the next seven years served successively as a general duty nurse, head nurse and assistant superintendent. In 1942 her association with the City Health Department began.

Study in public health nursing at the University of Montreal was followed, in 1953, by further postgraduate preparation at Teachers College, Columbia University where she obtained her Bachelor of Science degree and in 1954, her Master's degree, majoring in administration in public health nursing.

In 1951 Miss Dallaire was made a supervisor in the City Health Department and in 1954 she became an assistant chief nurse. In 1949 her services to the City were interrupted briefly when she went to Haiti to work on a pilot project in education under the auspices of UNESCO and WHO. She enjoys travel and this particular assignment combined work and pleasure. Completely bilingual, she enjoys reading, attends the theater as often as possible, and indulges in more travel when the opportunity presents itself.

This is a tribute to one general duty nurse but also, albeit indirectly, to the many others of her sisters in the nursing profession engaged in similar activity who may sometimes feel that their role is accorded little recognition.

Presently on duty in Montreal's Notre Dame Hospital is a Scottish Canadian graduate of that institution, class of 1912, **Rosalie Dunn**. Miss Dunn returned to general duty 10 years ago after 20 years of experience as nurse-inspector with the Metropolitan Life Insurance Company of Montreal, six years as director of nurses at Hôpital Bourgeois, Three Rivers, P.Q. and a similar length of time specializing in surgery in her home hospital. Her particular concern now is the patients admitted for neurosurgical treatment. She does not confine her interest to the hospital situation alone but in true application of "total patient care," she extends her services to the patient's family through understanding counsel and practical help in adjusting to the problems encountered in conditions involving the nervous system.

The wisdom of years of experience in her profession — both in the community and in the hospital — have given her the insight to recognize that your job, in many ways, is as interesting and as satisfying as you make it. It can be a daily routine of tasks performed efficiently but flavored with monotony and without recognition of the inherent implications or it can be a daily adventure spiced with the warmth of human relationships as the total picture is appreciated. Miss Dunn has demonstrated the latter course in an exemplary way.

Isabel Lane, the school of nursing adviser for the province of New Brunswick since 1951, has had to terminate her duties for personal reasons. Her resignation is a cause for sincere regret by the NBARN and the schools of nursing in the province.

Her personal concern for and interest in the student nurses and the very excellent rapport that she established with those responsible for the administration of the schools assured the success of the project. Miss Lane

ISABEL LANE

became the province's first school of nursing adviser in May, 1951 when the position came into being with the support of a Federal-Provincial grant. When the grant terminated last year the schools of nursing were so emphatic in their desire to have the service continued that the provincial association undertook financial responsibility for it.

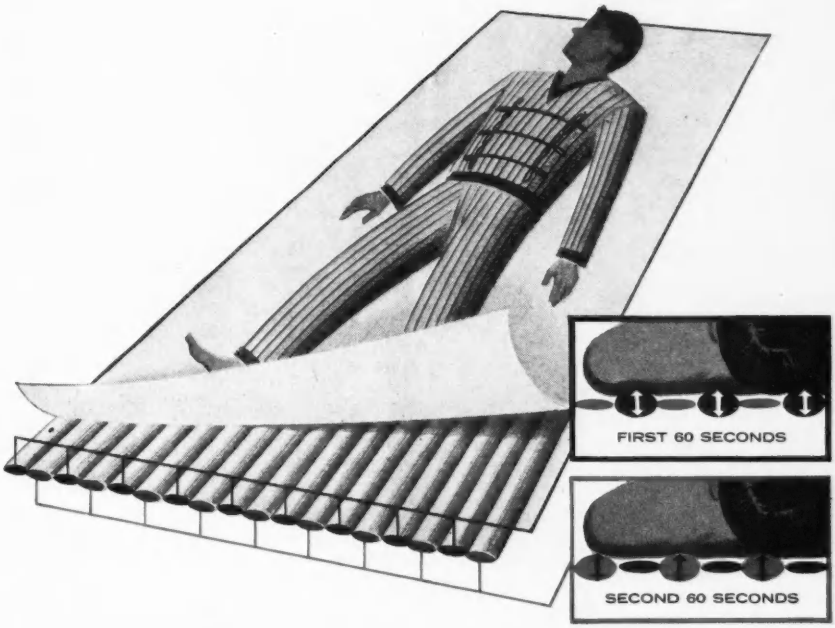
A graduate of Montreal General Hospital with postgraduate preparation in tuberculosis nursing and in teaching and supervision in schools of nursing, Miss Lane has had experience both in the institutional and public health fields prior to her advisory capacity. She will be greatly missed by those who worked with her and sought her counsel.

Laura Vrooman who has been in the service of the Ontario government since 1920 retired in December of last year. She was one of the first public health nurses appointed by the Bureau of Maternal and Child Hygiene under the provincial Board of Health.

In 1944 Miss Vrooman became a member of the Public Health Education Section of the Ontario Department of Health and for a number of years was in charge of the publications put out by the department.

A Memorial

At the suggestion of many of her friends, a memorial at Blue Mountain Camp, Collingwood, Ontario, is being planned for **Gretta Mackay Ross**, the first director of nursing and camps for the Ontario Society for Crippled Children. Blue Mountain Camp was the first of three camps opened and operated under Miss Ross' supervision. Those who may wish to add to the memorial fund can do so by sending their contribution to the **Ontario Society for Crippled Children, 92 College Street, Toronto.**



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please send reprints of the following articles:

- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

YOUR NAME AND ADDRESS

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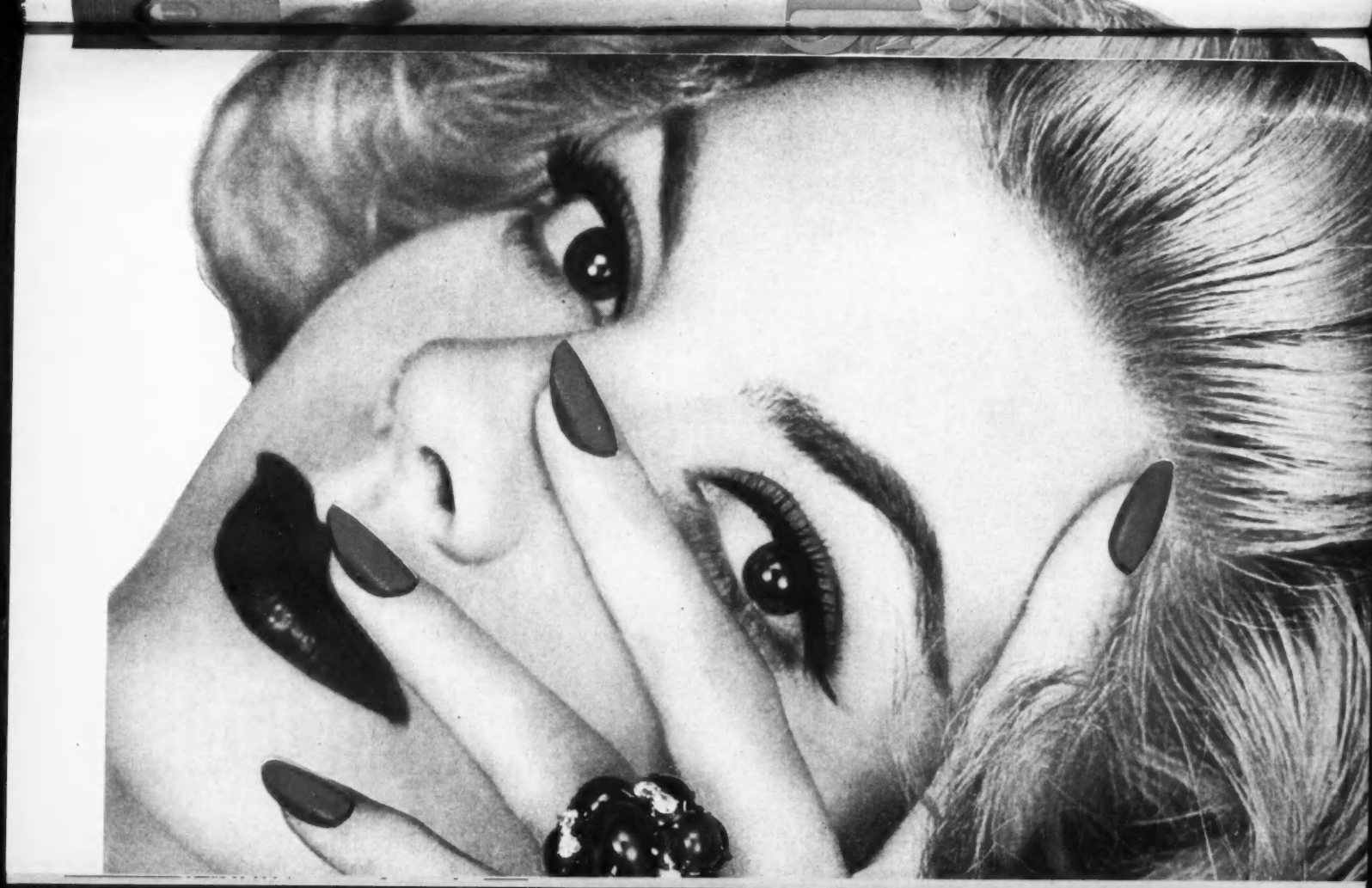

In Memoriam

Dorothy (Armstrong, Shapter) Arnold, who graduated from the Hamilton General Hospital in 1934, died in January, 1959. She did public health nursing in Guelph, Chatham and the Elgin-St. Thomas Health Unit from which she resigned in 1948.

* * *

Bertha (Samson) Beck a graduate of Winnipeg General Hospital in 1917 died in October, 1958. Mrs. Beck served overseas with the Canadian Army Medical Corps in World War I.

* * *

Alice E. Bingeman, a graduate of Roosevelt Hospital, New York, died on June 6, 1958. Following a short period spent in private nursing, Miss Bingeman joined the staff of Beck Memorial Sanatorium, London, Ont. Later she became superintendent of the Freeport Sanatorium, Kitchener, where she remained for 20 years until her retirement in 1948.

* * *

Frances May (Duncan) Burridge, who graduated from Winnipeg General Hospital in 1902, died November 3, 1958.

* * *

Jessie Gorden Campbell, a graduate of Toronto Western Hospital in 1917, died recently. At the time of her death she was engaged in private nursing.

* * *

Mary Palma Campbell, a graduate of the Infirmary and Fever Hospital and St. Mary's Obstetrical Hospital, Greenock, Scotland, died in December, 1958. Miss Campbell joined the Vancouver School Board as a school nurse in 1918. In 1936 the Metropolitan Health Committee of Greater Vancouver was formed and she was appointed a nursing supervisor of one of the new health units. She retired in 1940. An active member of the RNABC, Miss Campbell was its president 1929-33.

* * *

Doris (Dafoe) Cooper, a graduate of a Winnipeg hospital, died in September, 1958.

* * *

Diane Duff who graduated from Toronto Western Hospital in 1958, died on January 4, 1959 as the result of injuries received in a car accident. At the time of her death she was engaged in postgraduate study at the University of Western Ontario.

* * *

Mrs. **Olga Duncan,** a graduate of Vancouver General Hospital, died in Ventura, California in November, 1958.

* * *

Mona Elizabeth Easton who graduated from General Hospital, Brockville in 1949 died on November 13, 1958 from injuries received in a car accident. She was on the operating room staff of the Ontario Hospital, Brockville at the time of her death.

* * *

Anne Agnes Garles who had spent 20 years in nursing in Canada and the United States died in September, 1958 at Swift Current, Sask.

* * *

Florence Gibbons, a graduate nurse from England died on October 29, 1958 in Winnipeg where she had nursed since coming to Canada.

* * *

Jean (Taylor) Hallock who graduated from the Public General Hospital, Chatham, Ont. in 1920 died in October, 1958.

* * *

Frances Athil Harman who graduated from the Montreal General Hospital in 1909, died on September 15, 1958. She had served overseas with the Canadian Army Medical Corps in World War I.

* * *

Kathleen (Storozinski) Hopfner, a graduate of St. Boniface Hospital, Manitoba in 1956, died in October, 1958. She was on the staff of Johnson Memorial Hospital, Gimli, Man. at the time of her death.

* * *

Mary Constance (Partridge) Lee who graduated from Royal Victoria Hospital, Montreal in 1900 died in August, 1958.

* * *

Evelyn Lucie McElligott, a graduate of the Toronto General Hospital in 1936 died in October, 1958.

* * *

Jean Mary (Denovan) Norris a graduate of Royal Jubilee Hospital, Victoria, died in August, 1958. She served overseas during World War I in England and France.

* * *

Etta Alice (Timleck) Putnam, a graduate of Vancouver General Hospital in 1918, died in October, 1958.

* * *

Katherine Elizabeth (Underwood) Middleton, a graduate of an English hospital who devoted her professional life to work among the Blood Indians, Cardston, Alta.

died in August, 1958. She was matron of the Indian hospital for 21 years.

* * *

Norena Sara Mackenzie who graduated from Montreal General Hospital in 1926 died on January 13, 1959. At the time of her

NORENA MACKENZIE

death she was the director of nursing and principal of the school of nursing of the Jewish General Hospital, Montreal. In 1945 she was one of the Canadian nurses who went abroad to assist in the work of the United Nations Relief and Rehabilitation Administration. Miss Mackenzie served in Italy and in Germany where she developed an educational program for nursing assistants.

* * *

Gertrude May (Bellam) Reid who graduated from Souris Hospital, Man. in 1924 died recently.

* * *

Ada (Newton) Renton who graduated from Winnipeg General Hospital in 1899, died in November, 1958. Under her guidance the alumnae association of the hospital was developed.

* * *

Mary M. Roberts, one of the outstanding nursing leaders of the twentieth century, died on January 11, 1959. To Canadian as well as to American nurses she will be best remembered as the distinguished editor and later, editor emeritus of the *American Journal of Nursing*. She was associated with this publication for a total of 38 years.

Born in Cheboygan, Michigan, in 1877. Miss Roberts graduated from the Jewish Hospital Training School for Nurses, Cincinnati, Ohio in 1899. She secured her Bachelor of Science degree and her certificate in administration of nursing schools from Teachers College, Columbia University. Hospital work in various capacities was succeeded by an appointment as director of the Bureau of Nursing, Lake Division of the Red Cross and then one in 1918 as director of a unit of the Army School of Nursing. Eventually she became chief nurse of the Army Nurse Corps, a position she held until her discharge from military life in 1919. In 1921 Miss Roberts succeeded Miss Sophia Palmer, the first editor of the *American Journal of Nursing*. Under her skilful leadership the *Journal* experienced a tremendous growth in scope of interest and circulation.

In 1949 Miss Roberts retired as editor and became editor emeritus — a change that gave her the opportunity to maintain her contact with her beloved *Journal* while permitting her greater freedom for original writing. She was a prolific spokesman for the profession of nursing and her work as a historian has won particular acclaim.

The recipient of many honors, Miss Roberts numbered among them two of her

MARY M. ROBERTS

profession's highest tributes to outstanding leadership — the Florence Nightingale Medal and the Mary Adelaide Nutting Award. Writer, editor and historian, she has become a symbol of nursing through her professional stature.

* * *

Rachel (Monteith) Scarth who graduated from Winnipeg General Hospital in 1893 died in October, 1958.

* * *

Isabel (MacNicol) Sills, a graduate of Grace Hospital, Detroit died in October, 1958. She was the first collegiate nurse

in the province of Ontario and served on the Windsor Board of Education for 28 years.

* * *

Mrs. **Jane Stewart**, a graduate of a hospital in Toronto, died in November, 1958. She had nursed in the sanitarium at Ninette, Man. at one time.

* * *

Gladys F. (Cramond) Vanderburgh who graduated from Hamilton General Hospital died in August, 1958.

* * *

Alice (Hilton) Wadge, a graduate of Winnipeg General Hospital in 1903 died in November, 1958 after a lengthy illness.

* * *

Anita Welburn who graduated from Royal Victoria Hospital, Montreal in 1955 died from injuries received in a car accident on December 20, 1958.

* * *

Jean E. (Whitton) Wilson, a graduate of Victoria Hospital, London, Ont. in 1903, died on January 5, 1959. She had worked as a public health and school nurse for 25 years before her retirement.

Color in Your Home

Experts agree, dramatizing your house is easy — if you concentrate on *color*. The secret for successful completion of the formula is to aim for a coordinated color scheme — a plan where all the colors in a room harmonize or blend together. There are a few simple things to remember and then you, too, may be an expert. Avoid extremes. Avoid drab, matching colors like browns and grays which tend to be gloomy and boring. Avoid too many colors or distracting or meaningless contrasts.

Start with one basic color. To help you make the best choice — and there are no set rules for this — think first of the colors that you like and that would provide the most effective and attractive setting for your own coloring. Then, analyze the room: the use, the size, and the kind of light it will receive. Living rooms should emphasize bright, cheerful colors if a cozy, cheerful feeling for long stretches of time is desired. To carry out the restful theme for bedrooms, cool colors are best in quiet, harmonizing blends.

Red, yellow and orange tones are the warm colors best used in rooms facing north where there is little direct sunlight. Blue, violet and green tones are cool colors used to better advantage in sunny rooms.

Once you select your basic color, interest and beauty may be heightened by the way in which tones and shades of this basic color are duplicated throughout the room. The entire color picture can be enriched by the addition of complementary color shades. One easy method is to find the color desired in the pattern of an upholstery fabric or wallpaper. All the other shades are there, too — and you have the assurance of color combinations and patterns designed by professional artists. Just repeat the basic color of the pattern for the wall coloring; the deeper shades for the rugs; and the brighter colors for the accent notes of the sofa pillows or other accessories.

Although your redecoration has been started with color added to your walls the room still needs a finishing touch. None is more elegantly, tastefully supplied, than with wall-, window-draperies or curtains. They complete the room's dressed-up appearance much the same as gloves, purse and jewelery complete a fashionable outfit.

Inasmuch as draperies and curtains are usually grouped around window areas, they create a focal point. Usually they represent the largest vertical areas in a room and therefore have a major effect on the room's appearance. To make a room seem higher, use straight curtains which hang from the top of the window to the floor. Horizontal patterns will have the opposite effect.

— J. P. Stevens & Co., Inc.

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Ad Hoc Committee on Research Meets in Ottawa

Of all the recommendations presented to the Executive Committee of the Canadian Nurses' Association, more have to do with research than with anything else. Some which have come before the Executive in recent years would require a separate department within the CNA framework and would require more funds than the sum total of CNA revenues.

In times like these, when health programs are developing and expanding so rapidly, the need for research in nursing is ever-present and imperative. Where the CNA fits in, and how, is the important question. To answer these and other questions, the Ad Hoc Committee on Research met for three days in December, 1958, under the chairmanship of Miss ***Lola Wilson***, director, Study of the Aged and Long-term Illness, of the province of Saskatchewan.

The first thing the committee did was to accept a definition of "Research" — "Basic" and "Applied." The recommendations regarding research which had been referred to the Executive Committee during past years, were then studied and classified under such headings as "Nursing Needs of Society," "The Function of Nursing," "Philosophy, Aims and Objectives of Nursing Education," "Cost Studies," "Staff Utilization," etc.

The committee then went on to outline what it believes to be the areas of research in which the CNA should be involved and the sequence in which these activities should be undertaken. The committee also outlined recommendations which it believed were outside the CNA scope. Some of the suggestions classified under this heading, it was felt, might better fall within the range of provincial nurses' associations, universities, or at local level.

The committee established a priority for research projects and placed first on the list the establishment of a Nursing Research Index in National Office.

A full report of the committee's activities and recommendations will be brought to the Executive Committee of the Canadian Nurses' Association by the chairman at its meeting in February, 1959 in Quebec.

Projects for Committee on Nursing Service

At the December meeting of the Committee on Nursing Service, the following topics were considered of prime importance for this biennium.

1. Completion of a head nurse guide.
2. Study of the impact of hospital insurance on nursing.

A previous sub-committee had prepared material for a Guide for Head Nurses. It is planned to continue this work and to complete the Guide during this biennium. Based on the findings of "A Study of Functions and Activities of the Head Nurse in a General Hospital," conducted by the Research Division of the Department of National Health & Welfare, the guide will define the term "head nurse," outline her qualifications and preparation and define her functions and activities. It will also state general principles of administration, supervision and teaching and will clarify terminology.

Involved in the discussion of the impact of hospital insurance on nursing were the following topics:

1. The expected increase in patient census, longer stay and the increased demand for intensive nursing care resulting from newer medical and surgical treatments.
2. The responsibilities the nurses should have in the planning of new hospital construction.
3. The changing patterns of nursing needs in tuberculosis, mental hygiene, geriatrics, home care plans and the newer surgical procedures.
4. The changing role of the professional nurse and the need for adequate professional preparation for these new responsibilities.

Recommendations proposed by the Committee on Nursing Service for presentation to the Executive Committee will be discussed at the February meeting.

Calling all CNA Alumnae

Five years ago National Office circulated a questionnaire to 87 members of the "CNA Alumnae," graduates of the Metropolitan Demonstration School of Nursing, Windsor, Ontario. Through it we learned that 53 graduates were actively engaged in nursing. Of these, 18 had taken postgraduate university courses, 12 had entered the public health field, four had chosen nursing education and two hospital administration. Marriage of course, had claimed a goodly proportion but many of these were combining the two careers.

In January, because of continued interest in the activities of "CNA Alumnae" members, a second questionnaire was circulated. Through the kind assistance of one of the graduates, National Office has a list of current addresses. Among the missing are 16 graduates. Are you one of the 16 who did not receive a questionnaire? Perhaps you know of someone who should have received a questionnaire. If so, please send National Office a current address. Our sincere gratitude will be forthcoming.

The Canadian Nurses' Association is most anxious to keep in touch with members of its Alumnae.

Pilot Project Study Folio

The Study Folio on Accreditation has been revised in order to give you current information regarding the progress of the Pilot Project. Newer articles on accreditation are included in the folio. The bibliography has been revised to include recent articles on the subject of accreditation. French and English copies of this folio may be obtained on request from National Office.

CNA Building Fund

Appreciation

We wish to express sincere appreciation for the donations which have been made to the CNA building fund —

To Miss Florence H. M. Emory for the generous donation which started the fund.

To Dr. W. Stuart Stanbury for asking that the honorarium provided for the speaker giving the Mary Agnes Snively Memorial Lecture be added to the fund.

To Miss Ella Howard for visiting National Office during the meeting of the Committee on Nursing Service and adding to the fund.

Ideas for fund raising

The ever-active National Office Auxiliary has now arranged to serve refreshments following chapter meetings with proceeds going to the building fund. The February meeting of the Ottawa Area Chapter, R.N.A.O. District #8, was the first meeting at which this project was launched. We shall keep you posted on future activities.

Canadian Nurses' Association Retirement Plan

Have you enrolled in the CNA Retirement Plan?

The aim of the C.N.A.R.P. is to enable you to save for the future in a manner that will achieve the following objectives:

1. The money that you put into the plan will be deductible from your income for tax purposes.
2. By participating in a group arrangement with other nurses throughout Canada, you will obtain a better pension than you could on your own.
3. This plan has been especially designed

to provide an answer to the rising cost of living.

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WRITE TODAY

Le Nursing à travers le pays

Le Comité de Pension se réunit à Ottawa

De toutes les recommandations présentées au Comité Exécutif de l'Association des Infirmières canadiennes, la plupart se rapportent à la recherche. Parmi celles qui furent présentées au cours des dernières années, il y en a qui nécessiteraient l'établissement d'un département spécial, au sein de l'A.I.C. et qui demanderaient des sommes dépassant le revenu total de l'Association.

A une époque où de nouveaux programmes de santé se créent et se développent si rapidement, la recherche en nursing est d'actualité et s'impose. Quel est le rôle de l'A.I.C. dans ce domaine et par quels moyens peut-elle remplir ce rôle? Voilà la question importante. Afin de répondre à ces questions et à d'autres du même ordre, un comité spécial de recherche a tenu une réunion de trois jours à Ottawa, en décembre 1958, sous la présidence de Mlle Lola Wilson qui a fait, en Saskatchewan, une étude sur "Les personnes âgées et les malades chroniques."

Le comité commença son travail par l'adoption d'une définition des termes: "recherche," " de base," et "appliqué." Les recommandations portant sur la recherche, présentées au cours de ces dernières années au Comité Exécutif, furent alors examinées et classées sous les rubriques suivantes: "Les besoins de la collectivité en matière de nursing," "La fonction du nursing," "Philosophie, buts et objectifs de l'éducation en nursing," "Etudes du coût du nursing," "Utilisation du personnel," etc.

Le comité détermina alors les domaines dans lesquels, selon son point de vue, la recherche doit se pratiquer et l'ordre dans lequel l'A.I.C. doit procéder. Le comité fit aussi des recommandations concernant certaines questions qui ne relèvent pas de la compétence de l'Association, et dont certaines seraient plutôt du domaine des associations provinciales d'infirmières, des universités ou d'organisations locales.

Le comité a établi une priorité dans l'ordre des projets de recherche, et en tête de la liste a placé l'établissement, au Secrétariat national, d'un "Catalogue de recherches en nursing."

Un rapport complet du comité et des recommandations sera présenté au Comité Exécutif de l'A.I.C. par la convocatrice, lors de la prochaine réunion de l'Exécutif qui aura lieu à Québec en février 1959.

Projets du Comité du Service d'Infirmières

Lors de la réunion du Comité du Service d'Infirmières tenue en décembre, les points suivants furent jugés de première importance et feront l'objet des activités de ce comité au cours de la présente période biennale.

1. Le parachèvement d'un guide à l'usage de l'infirmière-chef.
2. Etude de la répercussion de l'assurance-hospitalisation sur le nursing.

Antérieurement, un sous-comité avait préparé la matière pour la rédaction d'un guide pour l'infirmière-chef. Le comité se propose de continuer et de terminer le travail commencé et de publier les résultats de cet ouvrage d'ici deux ans. Basé sur l' "Etude des Fonctions et des Tâches de l'Infirmière-chef dans un Hôpital Général," le guide définira le terme "infirmière-chef," les qualités et la préparation requises pour cette fonction. On y trouvera également les principes généraux de l'administration, de la surveillance et de l'enseignement. La terminologie employée dans ce manuel deviendra plus uniforme et, par suite, plus claire.

Au sujet de la répercussion de l'assurance-hospitalisation sur le nursing, les points suivants furent discutés:

1. L'augmentation éventuelle du nombre de malades, de la durée de l'hospitalisation, du volume de soins résultant de nouveaux traitements médicaux et chirurgicaux.
2. La responsabilité que les infirmières

devraient assumer dans la préparation des plans de constructions d'hôpitaux.

3. La modification des besoins du public concernant les soins en tuberculose, en hygiène mentale, en gérontologie, soins à domicile et traitements chirurgicaux.
4. Les changements dans le rôle de l'infirmière et la nécessité de donner à l'étudiante la préparation nécessaire pour lui permettre d'assumer ces responsabilités nouvelles.

Les recommandations faites par le Comité du Service d'Infirmières au Comité Exécutif seront étudiées lors de la réunion de février.

Appel à tous les membres de l'Amicale de l'A.I.C.

Il y a cinq ans, le Secrétariat national adressait un questionnaire à chacun des 87 membres de l'Amicale de l'A.I.C., diplomées du cours de démonstration donné à l'Ecole Métropolitaine d'Infirmières, Windsor, Ontario. Nous avons appris alors que 53 de ces diplômées exerçaient leur profession, dont 18 avaient fait des études post-scolaires à l'Université, 12 étaient engagées dans l'hygiène publique, quatre dans l'enseignement et deux dans l'administration. Le mariage avait réclamé sa large part mais plusieurs faisaient marcher de front les deux carrières.

Vu l'intérêt particulier que porte l'A.I.C. aux activités de ce groupe, un second questionnaire fut adressé à ces membres, grâce à l'obligeance d'une diplômée demeurée en relation avec ses compagnes. Seize diplômées n'ont pu être atteintes. Seriez-vous l'une des seize qui n'ont pas reçu le questionnaire? Connaissez-vous une infirmière qui aurait du recevoir un questionnaire et qui n'en a pas eu? S'il en est ainsi, veuillez donc faire parvenir l'adresse actuelle de cette personne ou la vôtre, s'il y a lieu, au Secrétariat national et soyez assurée de notre gratitude pour ce service. L'A.I.C. tient beaucoup à demeurer en relation avec les membres de son amicale.

Portefeuille — Projet d'accréditation

Le portefeuille ou garde-notes contenant les renseignements sur le projet d'accréditation des écoles d'infirmière a été revisé de façon à vous tenir au courant des progrès de cette entreprise. Des articles nouveaux sur l'accréditation y ont été ajoutés; la bibliographie a été revisée, et les plus récents articles sur l'accréditation y ont été ajoutés. Pour obtenir ce portefeuille en français ou en anglais, veuillez vous adresser au Secrétariat national.

Fonds de construction de l'A.I.C.

Nous voulons exprimer notre reconnaissance pour les dons reçus en faveur du fonds de construction de l'A.I.C.

A Mlle Florence H. M. Emory, pour son généreux don: le premier reçu.

Au Dr. W. Stuart Stanbury qui a demandé que le cachet offert au conférencier donnant le discours en mémoire de Mary Agnes Snively au Congrès Biennal, soit versé à ce fonds.

A Mlle Ella Howard, qui a visité le Secrétariat national à l'occasion de la réunion du Comité du Service d'Infirmières, et qui a fait un don.

Quelques idées pour alimenter ce fonds

Les dames auxiliaires du Secrétariat national ont décidé d'offrir des rafraichissements lors des réunions des divers chapitres et d'en verser les profits au fonds de construction. Ceci fut inauguré lors de la réunion du chapitre de la région d'Ottawa, District No 8. de l'Association des Infirmières de l'Ontario. Nous vous tiendrons au courant des initiatives prises à ce sujet.

PLAN DE RETRAITE DE L'ASSOCIATION DES INFIRMIÈRES CANADIENNES

Vous êtes-vous inscrite au Plan de retraite de l'A.I.C.?

Le but de ce plan est de vous permettre d'épargner en prévision de votre retraite de façon à atteindre les objectifs suivants:

1. L'argent que vous verserez au plan sera déduit de votre revenu imposable.
2. En participant à un plan collectif avec les autres infirmières dans tout le Canada, vous obtiendrez une meilleure pension que vous ne le pourriez individuellement.
3. Ce plan a été spécialement conçu en vue de compenser la hausse du coût de la vie.

Livrets d'instructions et cartes d'inscriptions peuvent être obtenus de:

L'Association des Infirmières Canadiennes,
270 ouest, avenue Laurier,
Ottawa, Ontario.
Ecrivez dès aujourd'hui.

The Canadian Red Cross Society has been serving Canada and the world since 1909.

a new look at

Some years ago there was a widely prevailing notion that bananas were indigestible. Today they are prescribed as one of the first solid foods fed to infants.

For the past few years many patients have had the idea, equally erroneous, that bananas are "fattening." The fact, of course, is that bananas—like fruits as a class—are relatively low in calories. There are only 88 calories in a medium banana, according to the Canadian Department of Agriculture. (Table of Food Values.)

And so another bugaboo is laid to rest.

There is no reason to omit bananas from reducing diets.

There are a wealth of reasons to include them:

- *A wide range of vitamins and minerals in good balance with calories.*
- *Calories provided both as simple sugars for quick energy and as less soluble carbohydrates for sustained vitality.*
- *High satiety value for appetite control.*
- *Pectins and carbohydrates to aid digestion.*
- *Extremely low fat content—less than 0.2 per cent.*
- *Sweet mellow flavor that rates high in patient acceptance.*

In addition, clinical experience has demonstrated the banana's regulatory effect on gastrointestinal function, and its value in the correction of both diarrhea and constipation.

A new look at bananas demonstrates their place in every reducing diet—and every normal or maintenance diet, too.

Bananas belong in the daily diet

CANADIAN BANANA COMPANY LTD.

Nursing in Psychiatric Divisions of General Hospitals

Report of a conference held on October 30 and 31, 1958 in the Allan Memorial Institute of Psychiatry, under the auspices of the Royal Victoria Hospital and McGill University.

The conference, the first such large gathering of its kind, was planned as a forum for the exchange of experience and thinking in the comparatively new area of psychiatric nursing in a general hospital. Hospitals and psychiatric clinics, serving both English and French-speaking patients from Ontario through to the Maritimes and from the North-Eastern Atlantic seaboard of the United States, sent representatives from their general and psychiatric nursing staffs. There were over 150 registered delegates from as far afield as British Columbia and the mid-western United States. A capacity audience of some 350 attended the final evening meeting which was open to all nurses. Miss Cynthia Lidstone, supervisor of nurses, The Allan Memorial Institute, chaired the Planning Committee for the conference.

From the beginning the conference was welcomed with enthusiasm by both general and psychiatric nurses. And further, the sessions proved to be so stimulating that requests were made by delegates that a similar conference be held annually.

Session Highlights

Speaking on the relationship between general and psychiatric nursing in a general hospital, Mrs. Isobel MacLeod, director of nurses, The Montreal General Hospital, stated that in her experience the presence of a department of psychiatry has greatly enriched the nursing care of patients in all sections of the hospital. She noted that within two or three years after the inauguration of the training program for student nurses conducted by the Department of Psychiatry, the impact began to be felt throughout the whole hospital, more so as these students joined the general staff upon graduation. A short time later a number of them were head nurses; then followed joint conferences arranged by the leaders in general nursing as well as by those in psychiatry which led to still further exchange. As a result the speaker felt all hospital patients today receive more 'comprehensive' nursing care.

Another 'educational' experience which more and more frequently involves groups of general staff nurses is the referral to psychiatry of patients first admitted to hospital with physical illnesses. When these patients are transferred to psychiatry, the nurses who care for them are genuinely concerned and want to know how their former patients are getting along. Nursing leaders promote this natural interest by planning exchanges of information between former and present nurses.

And finally, an exceedingly important conclusion was being reached by both general and psychiatric nurses: there are more similarities than differences in the nursing of patients in general medicine and those in psychiatry. The psychiatric nurse is beginning to look on her work as not so specialized after all; the general nurse is beginning to realize that every 'physical' illness has its psychiatric aspects too.

Miss Harriet M. Kandler of the Lafayette Clinic, Detroit, told the conference that the role of a head nurse in the general hospital ward and a head nurse in the psychiatric division of a general hospital is essentially the same. Miss Kandler, who recently conducted a notable four-year research project on the nurses' role in the socializing of mental patients, felt that a head nurse in the psychiatric ward has the added opportunity of carrying greater responsibilities in administration, in leadership and in educational programs for ward personnel.

The guest speaker of the evening dinner meeting, Dr. D. Ewen Cameron, director of The Allan Memorial Institute, called for a system of training of nurses which does not stamp out the individuality and creative ability of the individual nurse. He realized that those training nurses were responsible for turning a teen-aged girl into a woman on whom major responsibilities must rest.

"But," he stated, "I have never been content that it should be done at such a cost in freedom of thought, such a loss of creative thinking, of speculation and conjecture."

He continued: "I do not think it is beyond the capacities of able nurse educators and nurse administrators to work out a system of training nurses whereby the graduates will have sufficient flexibility to work as an

integral unit of the medical-nursing team under the direction of the doctor in the face of an emergency or in areas where unitary control is essential, yet at the same time be able to operate quite differently in terms of the freedom of thought, of speculation, inquiry and actual research activity when emergency demands are not present."

Speaking on "The Education of the Undergraduate and Postgraduate Nurse in the Psychiatric Division of the General Hospital," Miss Elizabeth Bregg, assistant professor of psychiatric nursing, Frances Payne Bolton School of Nursing, Cleveland, Ohio, described the education of nursing students as directly related to the kind of psychiatric care the particular hospital offered.

"If the psychiatric division is seen as a small mental hospital where, for the most part, decent custodial care is the aim, then the education offered students will be geared to this concept. Some psychiatric divisions are over-night stopping places or small alcoholic sanitaria. If such is the case, then the teaching of students will have to fit into this frame of reference. Whether such divisions are giving good or bad care is not the question to be decided here. The point is that there has to be clarification of philosophy and standards before any student can be expected to learn and function in the setting."

Miss P. C. Pike, head of the Teaching Department, The Allan Memorial Institute, noted that some of the fears the general nurse brings with her are the 'folklore of psychiatry' and are, in fact, attitudes prevalent in the community but not based on fact. These false notions include the popular idea that all psychiatric staff members are a little 'mad' and that mental illness is contagious.

"Many people, too, expect to find the psychiatric patient is mentally defective, although many of them personally know highly intelligent people who have had to be admitted to psychiatric hospitals. But offsetting these handicaps, the nurse brings many positive nursing qualities. She brings warmth and mothers a ward full of patients as she would the children she hopes to have."

Finally, the nurse has a fundamental desire to help others, a healthy curiosity about people and a sympathy for their problems. Her intelligence and above all her intuition, make her a valuable member of the treatment team.

Dr. T. J. Boag of the attending staff of The Allan Memorial Institute in speaking on "The Role of the Psychiatric Nurse Working in the Day Hospital" described the psychiatric nurse as a key figure in the Allan's Day Hospital. "She occupies a central position in its social structure, and exerts greater influence on it than does any other single person."

"But," Dr. Boag, continued, "this central position carries important implications for the functioning of the nurse. One necessity which should be self-evident, but which is often ignored, is that the composition of the ward staff must be reasonably stable. Frequent rotations create endless difficulties. The nurse must have guidance in the management of her relations with individual patients and this is best given by discussion sessions with the clinical team."

The speaker said that in order to plan programs and handle group activities for patients, the nurse needs help from a psychiatrist in a position to view the situation as a whole. She also needs his support and advice in the management of problems as they arise. If she does not get the necessary help, she is very likely to retreat into the security of the office and administration.

"Even with appropriate help," Dr. Boag concluded, "the nurse in a psychiatric division will find it difficult to move into programs which are foreign to her previous training and experience. It is essential, therefore, that attention be given to individual and group psychodynamics in the training of the psychiatric nurse. Continued in-service training in the form of seminars and discussion groups must run parallel to her work on the ward if she is to understand the problems she must handle every day and if she is to make the valuable contributions which only she, in her key position, can make."

Dr. Esther Lucile Brown of the Russell Sage Foundation, New York, addressed the final evening session which was open to all nurses. A consultant to World Health Organization, she has advocated a greater use of the social sciences in the field of nursing and has initiated a number of research studies dealing with the psychological and sociological aspects of patient care.

"One way to improve patient care is to bring into the hospital more of the positive values of family living and community life. In to-day's general hospital . . . too often patients are only regarded as so many horizontal figures under white sheets." Dr. Brown cited the exclusion from hospitals of children under 12 and animals when these may be of the greatest importance to the patient.

Hospitals should promote the individual's ability to help each other. Dr. Brown cited as proof of this the case of polio patients being treated in hot water swimming pools rather than in Hubbard tanks. In the Hubbard tank treatment, one patient and the therapist work together. In the swimming pool, the therapist can instruct a number of patients at once and they advance more rapidly by working together and by helping each other.

Another way to improve patient care is by giving psychological support to all the staff, "particularly those most immediately and directly in contact with patients. This support is needed to improve the motivation and efficiency of the staff."

While there is shortage of staff everywhere, Dr. Brown feels much of this shortage is due to the fact that what staff there is, is not fully utilized. To make people work to their full capacity and enjoy it, "they must be given on-the-spot recognition and praise, and they must be allowed to develop a group spirit without disruption through rotation."

People who work in hospitals are in what Dr. Brown describes as "an anxiety-inducing situation." Because of this, they must be allowed an outlet for their frustrations and anxieties without fear of being penalized.

Dr. Brown has great faith in the treatment of patients in small groups. By this she meant living and working together over a period of time. Through this method the patients are able to give a lot to each other and thus hasten their return to health.

Mental hospitals are much more experimental in their approach to patient treatment than general hospitals. "The general hospital talks about a total person but seldom is much known about the patient other than his disease and how to cure it."

JEAN MCCRIMMON
Mental Hygiene Institute
Pine Ave. West, Montreal

Alberta Certified Nursing Aide Association

MADELINE QUIRK

THE FIRST ANNUAL provincial convention of this organization was held in September at the Royal Alexandra Hospital, Edmonton. Sixty-seven delegates, representing many districts of the province attended. Alberta led the way in organizing the first association of this kind in Canada.

A pre-registration coffee party was held in the School for Nursing Aides. The hostesses were the members of the Edmonton Chapter and the trainees from the school. This was followed by a tour of the school.

The opening invocation was delivered by Rev. Wilson of the Norwood United Church. Messages of welcome were brought by Dr. Somerville, Deputy Minister of Health, Mrs. June Taylor, vice-president of the A.A.R.N., and Dr. Easton, administrator of the Royal Alexandra Hospital.

A highlight of the meeting was a panel discussion on "The Importance of Representation through an Organized Group." The chairman was Mrs. Dorothy Cameron, Parent Education Chairman of the Federation of Home and School Association, and the first vice-president of the Southern Group of the Alberta Region of the Canadian Mental Health Association. Panel members were: Mrs. Van Dusen, executive director of the A.A.R.N. and Mr. Miller of the Canadian Mental Health Association.

Dr. J. D. Griffin, National Director of the Canadian Mental Health Association was the guest speaker on the second day. He gave a most interesting talk on what mental health is and is not. This was followed by a buzz session and then a panel discussion.

Mr. Jim Rennie, public relations official of the Imperial Oil Co. spoke on the subject of public relations. One of the objectives of the A.C.N.A.A. for this year is to set up a Public Relations Committee and to establish a public relations program throughout the province.

A poster contest had been held during the convention and Miss Jean Gold of Ponoka was the winner. A new style of apron made of better material was modelled, and a resolution passed that the present style should be changed.

A feeling of good will and satisfaction that the first annual convention had been a success, was prevalent as the convention closed.

Book Reviews

Research in Nursing by Amy Frances Brown, R.N., B.Ed., M.S. in N., Ph.D. 352 pages. W. B. Saunders Company, Philadelphia, Pa. 1958. Price $5.75.

Reviewed by Miss Edith M. McDowell, Dean, School of Nursing, University of Western Ontario, London.

Dr. Brown, in her preface, states a basic assumption from which we derive an important criterion, "One of the characteristics of a profession is that it has a body of knowledge, the extension of which is directed by the members of that profession." That assumption should set in motion many kinds of activity, directed to the extension and refinement of the knowledge from which we derive principles and concepts for the practice of nursing.

The author presents her book as ". . . a compact source of information on research methodology."

Unit I discusses the meaning of research and briefly reviews the short history of the past decade which saw the beginnings of research activities in nursing — research *by* nurses *for* nursing.

Units II and *III* outline the process, step by step, of methods and procedures in the light of sound and acceptable research practice. Nurses will find Dr. Brown's definitions and methods of particular usefulness.

Unit IV turns the keen edge of research upon the clinical field as it is used in the education of students through practice in the care of patients. Two of the conclusions reached on the basis of completed studies should be especially provocative:

> . . . curriculum building has not been based upon any rationale of curriculum theory. . . . of the several methods (curriculum planning) which have been used, none has provided a satisfactory method of meeting the learning needs of students or the nursing needs of patients.

Chapter 13 cites briefly further studies that are needed in nursing.

Teachers in schools of nursing might well begin with Chapter 12 — "Methods of Case Analysis for Inferring Learning Needs."

We have long since recognized the intimate relationship that exists between *quality nursing for the patient* and *the needs of the learner*. The problems that arise because of our failure to admit this relationship have been our daily meat for many years. The "truth" which have usually presented in our defence is frequently derived from convenience, fear of dislocation of established routines and fear of change.

Administrators, teachers and practitioners of nursing will and should welcome Dr. Brown's book. It is not only a rich and significant contribution to the literature of our profession; it is a guide to the discovery of truth needed in facing contemporary responsibilities in education and practice.

Modern Pharmacology and Therapeutics by Ruth D. Musser, A.B., M.S. and Joseph G. Bird, M.D., Ph.D. 794 pages. Brett-Macmillan Ltd., 132 Water St. S., Galt, Ont. 1958. Price $6.75.

Reviewed by Margaret M. Egan, science instructor, General Hospital, Pembroke, Ont.

This is a comprehensive, detailed, modern pharmacology text that is adaptable to the capabilities of the student nurse. It covers all phases of the subject. For the beginner it provides the fundamental principles upon which the student can build knowledge acquired in the pursuit of her profession. Older concepts that have been supplanted by newer ideas and methods have been deleted. The student is not burdened with information that is no longer applicable. For the more advanced student drugs are presented under the various functional units with clinical and pathological illustrations showing the relationship of the disease to the drug and its action. This approach should enable the nurse to organize and retain knowledge with greater ease.

Other noteworthy points are the thought-provoking questions and references listed at the end of each chapter and the diagrams and tables used throughout the book. The subject of drug addiction is well discussed and provides much information.

The content of the text provides for more than the needs of student nurses. For this reason it should be valuable for students in related fields, for instructors or as a library reference book.

Evaluation in Basic Nursing Education by Mary Tschudin, Helen C. Belcher and Leo Nedelsky. 304 pages. G. P. Putnam's Sons, 121 Sixth Ave., New York 13, N.Y.

Reviewed by Miss Alma E. Reid, Hamilton College, McMaster University, Hamilton, Ont.

Are you interested to know how one school of nursing is carrying out a comparative study of two basic programs, one experimental and the other established; has sorted out and agreed upon a general theory of educational measurement whereby the two curricula may be evaluated; has arrived at objectives of content and behavior that students in basic nursing education should attain; has evolved methods of evaluation in all fields of clinical nursing including public health nursing; has devised means whereby principles from the natural and social sciences may be elicited and tested in nursing practice; has described a variety of techniques that may be used in evaluating nursing practice? If so, go to this book, for in it all these and many other interesting questions are discussed.

This is the second volume of the report of the five-year curriculum research project in basic nursing education, begun in 1952 at the School of Nursing, University of Washington, Seattle. The project has to do with the improvement of instruction in basic nursing education so that a "competent" professional nurse may be prepared in a shorter period of time. In the first volume of the series reporting on the project, *Curriculum Study in Basic Nursing Education* by Ole Sand, the basis of the project was outlined and discussed. It seemed logical and essential that evaluation should take a central and important place in the study and that the next volume should be devoted to this topic. Here, in the words of the authors, this is stated, "We found that evaluation is an integral part of curriculum study; that evaluation is essential to determine whether students have attained curricular objectives and to what degree." Hence the second volume, with evaluation quite rightly enjoying the limelight of the project.

Those of us who have struggled with this difficult and important question of evaluation in nursing will read this account with intense interest and will assuredly welcome some new ideas on the subject. While it is acknowledged by the authors that all their problems of evaluation in basic nursing education are by no means solved or even tackled in this treatise, nevertheless considerable light is shed on interesting and new possibilities — possibilities that are stimulating and well deserved exploration in our own situations. This worthwhile project in curriculum research gives us relevant findings which undoubtedly can be helpful to us in our own programs in nursing education.

Nurses are invited to be the guests of the American College of Surgeons at a four-day meeting of the College in Montreal, P.Q., April 6-9, 1959. Housing and meeting headquarters for the nurses will be at the Sheraton Mount Royal Hotel. This invitation includes attendance at extensive programs arranged for nurses, hospital visits, various demonstrations and attendance at all sessions prepared for surgeons and surgical specialists.

The meeting is planned for the interest of all personnel concerned with treatment of surgical patients — from preoperative work-up through anesthesia, operating room, recovery room, postoperative care and rehabilitation.

A good deal of ritual was always part of all primitive medicines. The following is an Irish cure for mumps. "Tie a halter round the neck of the child and lead him to a brook. Bathe him three times three in the name of the Blessed Trinity."

— Encyclopedia of Superstitions

Garbage in the Sky

If all the dirt that accumulates in the air of an average city in one year settled to the ground at once, the city would be covered by a 21-foot avalanche of soot and debris! The possibility of such a disaster is remote but the murky cloud hanging over the heads of urban dwellers in particular is causing grave concern.

Within recent years people have died because polluted air settled like a heavy blanket over the area and did not raise for several days. For example, in London, England, the death toll was estimated in thousands during the acute episodes of air pollution in 1948, 1952 and 1956. In the interval it was discovered that others who had been exposed to the effects of severe air pollution and were seriously ill as a result of it, have tended to become ill with greater frequency and have a shorter lifespan.

Air pollution is directly related to the incidence of chronic bronchitis — a condition ranked as third in the causes of death in England, although we do not rate it so on the North American continent. There has been widespread condemnation of cigarette smoking as a cause of lung cancer but less well advertised is the fact that mortality rates for lung cancer are noticeably higher in urban as compared to rural areas *regardless* of smoking habits.

Sulfur oxides in the air tend to make breathing more difficult. Ozone, which occurs in some air supplies, has been found to cause scarring of lung tissue in animals and may also cause pulmonary edema. Eye irritation is a common complaint. Evidence is beginning to accumulate that makes air pollution suspect in such conditions as arteriosclerotic and other heart conditions, cancer of the trachea, stomach and esophagus.

If you need further proof that the air around you is not as pure as you think it is — consider the size of your yearly cleaning bill; count up the number of times your white curtains have gone to the laundry; glance in the mirror at your soot-speckled face after a trip downtown; talk to the real estate agent who is trying to sell housing profitably in a highly industrialized area. One American city estimated that property values were declining $25 million a year before it began a clean air campaign.

Unfortunately more than one chemical agent is involved in air pollution. Otherwise, control measures would be simple since industry could remove the offender from discharge waste products. The toxic substances are the end-products of chemical interaction among the combined total pollutants of a city. During an acute episode a heavy fog containing the pollutants — chemicals, smoke or fumes — settles over the area and is held in place by a layer of heavy, cold air that acts like the lid on a jar. Generally speaking, the aged and infirm tend to die from the effects and serious illness results in other.

What is being done to control air pollution? In the United States, as an example, industry has been spending millions of dollars yearly on methods of control. Some cities prohibit the use of certain fuels for furnaces — fuels that do not burn efficiently and therefore discharge unspent gases into the air. "After-burners" — devices to oxidize more completely or burn the fuel in the automobile exhaust — are being developed. There is a possibility that in some cities where air pollution is a particular problem, each car may be required to have an afterburner. Air conditioning units do help to a certain extent by filtering out dust and other particles. Research is going on constantly to determine just what the effects of air pollution are biologically. The knowledge gained so far has been encouraging.

Eventually when the city dweller puts on his hat and coat to step out for "a breath of fresh air," he may be able to get it.

The week of February 1-7 was set aside as National Health Week in Canada. Medical science has made great strides but —

One out of every 50 Canadian adults is an alcoholic; the number of alcoholics has doubled in 10 years: there are only five countries with a worse rate of alcoholism than Canada.

Over 95% of the population of Canada is afflicted with diseases originating in the mouth and diseases resulting therefrom. There is only *one* dentist for every 3000 Canadians. Fluoridation of communal water supplies can positively prevent 60% of tooth decay.

Over 500 million dollars is lost annually in wages through absenteeism, much of which is preventable.

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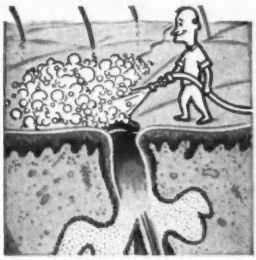
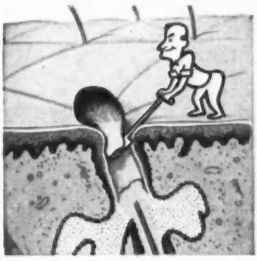
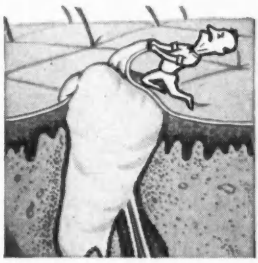


Fostex contains a combination of surface active agents (Sebulytic*) which:

◂ Completely emulsify excess oil so that it is quickly washed off the skin.



◂ Penetrate and soften comedones, unblocking the pores and facilitating removal of sebum plugs.



Fostex dries and peels the skin

◂ The Sebulytic base of Fostex dries and promotes peeling of the skin . . . actions enhanced by the keratolytic effects of micropulverized sulfur and salicylic acid.

*(Sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate, sodium dioctyl sulfosuccinate.)

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FOSTEX CREAM
for therapeutic washing of skin in the initial phase of acne treatment, when maximum degreasing and peeling are desired.

FOSTEX CAKE
for maintenance therapy to keep skin dry and substantially free of comedones.

◂ Patients stop using soap on affected skin areas. Instead they use Fostex for therapeutic washing of the skin. The Fostex lather is massaged into the skin for 5 minutes—then rinse and dry.

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Ontario

The following is a list of changes in the Ontario Public Health Services.

Appointments — *Elizabeth M. Hanna,* (Toronto Gen. Hosp., Univ. of West. Ont.) and *Georgette Proulx,* (Ottawa Gen. Hosp., Univ. of Ottawa) formerly of Prescott and Russell Health Unit to Carleton H. U. *Norma L. Compton,* (T.G.H., U.W.O.) to Chatham Board of Health. *Marjorie Sykes,* (Hamilton Gen. Hosp., Univ. of Toronto) to Haldimand Co. H. U. *Vernanne G. (Purdy) Drummond,* (U. of T. S. of N., U. of T.) to Kitchener B. H. *Carolyn (Greenwood) Daley,* (The Presbyterian Hosp., New York, U. of T.) to Lennox and Addington H. U. *Marion (McEachran) Gauvreau,* (Victoria Hosp., London, U.W.O.); *Debora (Merkus) Dykstra,* (City Hosp., Leeuwarden, Prov. Friesland, Netherland) and *Barbara J. Irwin,* (Toronto West. Hosp., U.W.O.) to Middlesex Co. Health Service. *Ethel Vera Slocombe,* (H.G.H., U. of T.), formerly of Dufferin Co. H. U. and *Mary Ann (Empey) Kerr,* (Royal Jubilee Hosp., Victoria, Univ. of Alta.) to Oshawa B.H. *Leonida Fillion,* (St. Croix Hosp., Drummondville, P.Q., Univ. of Montreal) to Stormont, Dundas and Glengarry H. U. *Blanche Gordon,* (T.W.H., U. of T.) to York Co. H. U.

Resignations — *Helen (Wray) Currie,* from Ayr and N. Dumfries Township, Waterloo Co. *Winona Inches, Alice G. Keryluk, Adele M. Fetterley, Sheila McLeod, Audrey Seifred* from Fort William and Dist. H.U. *Lois Humphries, Lassy Malowany, Sylvia Young,* from Kenora Dist. H.U. Mrs. *Lillian McLean,* from Lincoln-St. Catharines H.U. *Elizabeth (Burn) Nicolson,* from Leeds and Grenville H.U. *Mary E. Highstead,* from Middlesex Co. School Health Services. *Margaret Winfield,* from Muskoka and Dist. H.U. *Bee H. McKerracher,* from Oshawa B.H. *Margaret Hill,* from Timiskaming H. U. *Mary Isabel (Sheller) Coome, Margaret J. (Kernaghan) Hefferon,* and *Audrey Ruth Wale (McDermott,)* from Scarborough B.H.

Retired — *Margaret Nealon,* from Guelph B.H.

Since its inauguration in 1947, the Canadian Red Cross free blood transfusion service has supplied more than 2,500,000 bottles of blood for free transfusions to patients in Canadian hospitals.

Dictionaries are like watches; the worst is better than none, and the best cannot be expected to go quite true.

News Notes

ALBERTA

The members of Hinton chapter heard reports from Mrs. D. Hallam and E. Dragland, at their January meeting, of the conferences they had attended earlier. Members of the 1959 executive were elected and a membership fee decided upon. Drumheller chapter reported the addition of several new members and decided on a regular meeting time of the first Wednesday in each month. Westlock members held their first meeting of the new year as a combined annual meeting and dinner party. New officers were elected — Mrs. P. Leriger, pres.; Mrs. L. Schmuland, vice-pres.; Mrs. R. Renaud, sec.; J. Montgomery, treas. High River chapter gave a donation of $50 for furnishings for the new office building and elected its new executive: Jean Squire, pres.; Beverly Cross, vice-president; Mildred Cox, secretary; Nellie Caswell, treasurer.

District 3

Calgary

Holy Cross Hospital

The alumnae association recently elected its new executive. The members in office are: Mrs. W. MacDonald, past pres.; Mrs. F. E. Hammer, pres.; Mrs. A. M. S. Brown, vice-pres.; Mrs. P. Poole, rec. sec.; E. E. Newton, corr. sec.; Mrs. C. F. Jackson, treas.; Mrs. E. Wright, courtesy; Mmes K. Calvert, A. Benner, Miss R. O'Byrne, membership; Mmes A. Fitzsimons, E. J. Valentine, V. O'Connor, paper; Mmes E. Sikna, L. Leach, Miss Hotsenpillar, refreshments; J. McGowan, J. LaCaste, Mmes K. Moore, H. C. Johnson, program; Mmes G. Powell, A. Swidinski, A. Beavers, Miss J. Cummins, ways and means.

District 4

Medicine Hat

Twenty-three members attended the annual meeting of the chapter in January. Nominations for the offices of president and vice-president of the AARN were received and are to be submitted to the provincial nominating committee. The director of the community nursing registry reported a total of 298 calls for the year 1958 of which 62 were not filled. The chapter executive for this year is: Mrs. L. G. Desharnais, pres.; R. Ziehran, Mrs. D. Stevenson, vice-pres.; F. Ireland, sec.; W. Schmidt, treas.

The guest speaker for the evening, Mr.

L. King, outlined developments in civil defence for the area.

District 7

Edmonton

Royal Alexandra Hospital

Members of the alumnae association elected the following slate of officers at their annual meeting: Mrs. O. Hennig, pres.; J. Taylor, D. Watt, vice-pres.; Mrs. O. Tookey, rec. sec.; Mrs. B. Ofstadal, corr. sec.; M. Goodland, treas.; L. Clark, social convener; Mrs. H. McMillan, assistant social convener; J. Hamilton, scholarship; W. Riley, benefit & loan; M. Cameron, sick visiting; Mrs. M. McLeay, Blue Book; Mrs. O. Morrison, news letter; Mrs. D. Fraser, press and rep. to *The Canadian Nurse*; Mrs. B. Marples, Local Council of Women; Mrs. O. Moore, United Nations.

University of Alberta Hospital

The new officers of the alumnae association were installed at a recent meeting. Forming the executive are: Patricia MacMillan, president; Mrs. J. Edwards, vice-pres.; Mrs. K. Hodgson, rec. sec.; Mrs. P. Stewart, corr. sec.; Mrs. H. Hole, treas.; Mmes F. D. Mace, W. J. McLihan, program committee; Mmes G. W. Elkington, S. Antonink, social committee; Mmes J. E. Greenaway, R. B. Cox, W. M. Taskey, membership committee.

BRITISH COLUMBIA

Comox

Members of the Plateau chapter met at St. Joseph's Hospital recently and elected their executive for this year. Mrs. W. K. Hind accepted the presidency with Mrs. M. Calnan, vice-pres.; Sr. M. Alan, rec. sec.; Miss Scavarda, corr. sec.; Mrs. Dansereau, treas. Mrs. Hind presented her report of a provincial council meeting held in Vancouver, and Sr. St. Thomas described the inservice training institute held at Nanaimo.

Kamloops

Royal Inland Hospital

As their own particular project in recognition of the province's Centennial, the alumnae association purchased a Multiplex swing panel on which pictures of the graduating classes throughout the hospital's history will be mounted. When completed the panel will be placed in the new nurses' residence. During Her Royal Highness, Princess Margaret's visit, Mrs. Rawson, a graduate of 1915 and a former member of Queen Alexandra's Imperial Nursing Service, was presented. At the final meeting of the year the new slate of officers was elected: Mrs. R. Jamieson, pres.; Mmes A. Barclay, D. Fraser, vice-pres.; Mrs. A. Duck, sec.; G. Taylor, treas.

MANITOBA

District 2

Brandon

General Hospital

Members of the alumnae association enjoyed an informal social evening featuring singing, contests and a monologue at one of their recent regular meetings. Mmes D. Speakman, D. J. Cowie and Miss M. Jackson were the contest winners. Mrs. R. Griffin, and Mrs. D. L. Johnson, were in charge of arrangements.

WINNIPEG

General Hospital

The alumnae association has tentatively set the date for the annual tea party for early April. The graduation dinner and dance is to be held May 6 at Royal Alexander Hotel.

Following one of their general meetings the members were shown through the new wing of the hospital. The starting point was the front entrance on William Avenue and from there through the White Cross Guild Gift and Flower shop, the business offices, the administrative and nursing service offices; the laboratories, records, x-ray, pharmacy and out-patient departments and one of the semiprivate wards. In all areas, special attention was directed to the many time-saving and up-to-date facilities.

Miss Irene Cooper as guest speaker at another meeting shared some of the highlights of her work as relief instructor in obstetrics at the Nursing School in Alexandria, Egypt. She was away five months and during that time, she experienced many unusual situations, each of which was most vividly described.

December brought forth the spirit of Christmas and the desire to share Christmas stories and carols with friends. Rev. Philip Petersen of the Unitarian Church related at the Christmas alumnae meeting how the many practices and customs of Christmas came into being — the singing of carols, decorating the tree, the use of lights, burning the Yule log. Complementing this narrative was the singing of Christmas selections by the Student Nurses' Glee Club and the reading of the Christmas story from the Bible.

NEW BRUNSWICK

MONCTON

A regular meeting of the local chapter of the NBARN was held in the nurses' residence of Moncton Hospital recently with 27 members present.

In compliance with a request from the provincial office a survey of service clubs in the city is to be carried out to determine their various health projects. Guest speaker for the evening, Miss Dell McAuley, a member of the city council, was introduced by Mrs. Roberta Perry. Miss McAuley's talk on "Civic Affairs" was most informative and interesting and was followed by an open discussion.

NOVA SCOTIA

WINDSOR

The Christmas meeting of the Cape Breton and Victoria Branch of the RNANS was held at St. Elizabeth Hospital, North Sydney. Preclinical students from the hospital and local high school students presented a musical program of carols and Scottish songs.

ONTARIO

District 1

Chatham

Public General Hospital

At the annual alumnae meeting, Mrs. Margaret Fraser was elected president; Annie Head and Mrs. J. K. Keenan, vice-presidents; Mrs. C. Bennett, recording secretary; Mrs. D. Nichols, corresponding secretary and Winnifred Fair, treasurer. Mrs. G. Brisley is the representative to *The Canadian Nurse*.

Windsor

Hotel Dieu Hospital

Among the new executive members of the alumnae association are: F. Fortune, pres.; J. Cazabon, vice-pres.; R. Goldhawk, treas.; R. Labute, rec. sec.; L. Burke, social sec. The new officers were officially installed at the January meeting. Mrs. D. Kurcz was a guest of honor at a party in the nurses' residence prior to leaving the staff. E. (Ballard) Nader is working at the Methodist Hospital, Arcadia, California. C. (Caza) Bogard is on the staff of a medical center in Knob Noster, Missouri. B. (Foster) Perry is on the staff of Detroit Memorial Hospital and S. Fyfe is office nurse for a doctor in the same city.

District 2

Brantford

General Hospital

During the past months the alumnae association entertained the members of the graduating class and were hostesses to outside graduates who attended a regular meeting at which Dr. B. Henry was the guest speaker. Mr. B. Beaumont of the Community Welfare Bureau spoke to the members on another occasion and described the activities of his organization. In the same month a very successful fashion show featuring winter clothing was held. The graduating class presented "Follies of '58" at the last regular meeting of the season as their contribution to a delightful social evening.

District 3

Guelph

St. Joseph's Hospital

At the first regular meeting of the alumnae association in the new year, the following members were elected to office: G. Miiler, pres.; Mrs. A. Mezzabotta, vice-pres.; Mrs. A. Watson, rec. sec.; M. Ford, corr. sec.; C. Beliski, treas.; S. Turner, social convener; M. Hanlon, sick call convener.

District 4

Hamilton

St. Joseph's Hospital

The alumnae association has elected its new slate of officers. Included in the executive are: Mrs. L. MacKenzie, pres.; Mrs. E. Newman, vice-pres.; Mrs. E. Marcaccio, corr. sec.; Mrs. S. Rumbles, rec. sec.; W. Walker, treas.; T. Malone, rep. to press and *The Canadian Nurse*; Mmes D. Markle, H. McManamy and Miss M. Hays, advisory board. During the past holiday season, gift hampers were distributed to four needy families. Dr. Krar, one of the city's obstetricians, spoke at a recent meeting and reviewed the developments in his field and the subsequent effects on the practice of obstetrics. Mrs. A. Petrie, a former St. Elizabeth visiting nurse demonstrated some of the prenatal exercises presently in use.

District 5

Uxbridge

Cottage Hospital

Helen Hughes, former director of nurses at Cobourg District Hospital, has become superintendent of nurses of the new hospital in this area. The hospital opened in January of this year.

District 6

Campbellford

Memorial Hospital

Vera B. Eidt was appointed director of nursing late last fall, following postgraduate study at the University of Toronto. Immediately prior to her university work Miss Eidt had been the director of nursing at the Trail-Tadanac Hospital. She is a graduate of the General Hospital, Guelph.

SASKATCHEWAN

Swift Current

Ann Knievel has resigned as treasurer of the chapter and will leave the city shortly to become matron of the hospital at Rossburn, Manitoba. Miss Antonini attended the January meeting from the SRNA provincial office and urged members to improve attendance at the annual convention to be held at the Bessborough Hotel, Saskatoon, May 21, 22. Helen Talpash was appointed to represent the chapter at a nomination committee meeting to be held in Regina. Dr. F. Grunberg, director of the local mental health clinic, was the guest speaker and discussed the emotional aspects of hospitalization for mental patients. His audience participated in a lengthy discussion and question period, concentrated on the newer ideas in treatment of mental illness and the relationship between patient and nurse.

Employment Opportunities

ADVERTISING RATES — *$5.00 for 3 lines or less; $1.00 for each additional line.*
U.S.A. & Foreign — *$7.50 for 3 lines or less; $1.50 for each additional line.*

Closing date for copy and cancellations: 1st of the month preceding the month of publication. All letters should be addressed to: The Canadian Nurse Journal, 1522 Sherbrooke St. W., Montreal 25, Quebec.

Director of Nursing for new 33-bed General Hospital with well equipped surgery wing, in new mining town, about 250-mi. east of Port Arthur & northwest of White River, Ontario. Starting salary commensurate with experience & qualifications. Apply, stating qualifications, experience, age, marital status, etc. to Mr. W. Harrison, Room 1715, 44 King Street West, Toronto, Phone EMpire 4-1194, or to the Administrator, Manitouwadge General Hospital, Manitouwadge, Ontario, Phone TAylor 6-3251.

Director of Nursing for 180-bed hospital with a school of nursing. Applicant with University Degree &/or postgraduate course preferred. Salary commensurate with experience & qualifications, position available May 1959. Apply: Secretary, Board of Directors, Victoria Union Hospital, Prince Albert, Sask.

Director of Nursing Education for 500-bed General Hospital with school of nursing. Applicant must have a degree in nursing. Salary commensurate with experience & qualifications. Apply to, Director of Nursing, Royal Jubilee Hospital, Victoria, British Columbia.

District Supervisor (after July 1, 1959) Responsibilities would include the supervision of three (3) small health centres. Existing salary range $4,140-$4,740 with a yearly increment of $150. A certificate in Administration & Supervision in Public Health Nursing & experience in an official agency are essential. Good personnel policies. 5-dy. wk. Superannuation, Ontario Hospital Insurance, Blue Cross & P.S.I. benefits. For further information please apply to Director of Public Health Nursing, City of Ottawa Health Dept., City Hall, 111 Sussex Drive, Ottawa, Ontario.

Night Supervisor (8:00 p.m.-8:00 a.m.) 4 nights weekly for small Tuberculosis Hospital. Write stating age, experience, when available to Director of Nursing, Grace Dart Hospital, 6085 Sherbrooke Street East, Montreal, Que.

Obstetrical Supervisor for 10-bed 12-bassinet unit with 14-bed Woman's Surgical Unit on same floor. Willing to give Obstetrical Nursing lectures, clinics & supervise students. Medical staff teaches Obstetrics. Remuneration according to qualifications & experience. New school & residence under construction. Transportation allows easy access to Edmonton 40-mi. S.W. Travel expenses reimbursed after 1-yr. continuous service. Apply: Director of Nursing, Archer Memorial Hospital, Lamont, Alberta.

Operating Room Supervisor, Operating Room General Duty Nurse for 110-bed modern hospital. Excellent personnel policies. Apply: Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

Operating Room Supervisor (Immediately) for 86-bed hospital. Good salary, employee benefits & statutory holidays, living accommodation available in residence. Locate in Collingwood & enjoy many winter sports along with excellent skiing in the Blue Mountains. Apply, Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

Operating Room Supervisor (Experienced in general surgery) for 64-bed hospital. Good personnel policies, with sick benefits; holidays & paid vacation. Residence accommodation available. Salary commensurate with experience. Apply to Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

Operating Room Supervisor for active General Hospital in Niagara Peninsula. Postgraduate education required or background of supervisory experience. Apply: Director of Nursing, County General Hospital, Welland, Ontario.

Operating Room Supervisor (Qualified) for 82-bed accredited hospital. Salary $295-$335 per mo. 40-hr. wk. 21 holidays after 1-yr. of service (plus statutory holidays). Living accommodation in separate nurses' residence & laundry of uniforms provided for $12 per mo. Apply: Superintendent of Nurses, Union Hospital, Carora, Saskatchewan.

Nursing Supervisor for northern hospital. Good salary, good living conditions. Apply: The Matron, Yellowknife District Hospital, Yellowknife, North West Territories.

Instructress willing to plan class room program & teach. School enrollment 35-45 students. 4 affiliation courses, block system lectures, new school of nursing & residence under construction. Remuneration according to qualifications & experience. Hospital 40-mi. N.E. Edmonton. Transportation permits for interests in Edmonton. Travel expenses reimbursed after 1-yr. continuous service. Apply Director of Nursing, Archer Memorial Hospital, Lamont, Alberta.

Superintendent of Nurses for modern 23-bed hospital, 40-hr. wk. salary range $310-$395 per mo., board & room $34.50 per mo. Separate suite in new nurses' residence. Excellent train & bus connections with Prince Albert, Saskatoon & Regina. Apply giving qualifications to J. L. Fawcett, Sec.-Manager. Union Hospital, Rosthern, Saskatchewan.

Matron for 18-bed hospital, salary $350 per mo. less $35 maintenance. **X-ray & Lab. technician** — reply salary expected based on experience. 70-mi. S.E. from Winnipeg. Daily bus service. Vita Hospital District No. 28, Vita, Manitoba.

Matron: Salary $350 per mo. **Registered Nurses** (2) Basic salary $275 per mo. for 18-bed hospital. Residence available. 70-miles southeast of Winnipeg. Daily bus service. Apply: Vita Hospital District No. 28, Vita, Manitoba.

Assistant Head Nurses excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurse (1) Immediately for 30-bed hospital. Salary $260 per mo. gross, health & pension plans available. Straight 8-hr. rotating shifts. 44-hr. wk. 3-wk. vacation with pay after 1-year plus all statutory holidays. Within 1-hr. drive from Waterton National Park, 20 minutes from Lethbridge & 3-hr. from Calgary & Great Falls, Montana. Apply Matron, Municipal Hospital, Magrath, Alberta.

Registered Nurse for 35-bed busy General Hospital offers a variety of experience. 40-hr. wk., rotating periods of duty. Gross salary $270 per mo. $35 deducted for maintenance & laundry. 4 semi-annual increments of $5.00, 3-wk. vacation, 10 statutory holidays, 12 days sick leave each year, cumulative to 30-days. Accommodation in hospital wing — single & double rooms. Viking is 90-mi. southeast of Edmonton, on main highway & railway with daily bus & train service. Apply to Matron-Supt., Municipal Hospital, Viking, Alberta.

Registered Nurses (2) for modern 10-bed hospital. Working & living conditions excellent. Salary $260 per mo. with $5.00 increments each 6-mo. for 4 increases. 44-hr. wk. & 4-wk. vacation with pay after 1-yr. service. Living deduction $35 per mo. Apply to: Miss E. Curry, Matron, Nursing Unit, Pilot Mound, Manitoba.

Registered Nurses for modern hospital, comfortable home. Starting salary $250 per mo. maintenance $35 per mo. Apply: Superintendent, Lorne Memorial Medical Nursing Unit, Swan Lake, Manitoba.

Registered Nurse for 11-bed hospital. 4-wk. vacation after 1-yr. sick leave, living quarters at hospital. Apply stating experience & salary expected to Secretary-Treasurer, Harvey Community Hospital, Harvey Station, New Brunswick.

Registered Nurses: for 50-bed Hospital Obstetrical & General Duty. Rotating shifts, 40-hr. wk. Apply: Director of Nursing, Ajax & Pickering General Hospital, Ajax, Ontario.

Registered Nurses (for General Duty & Special Departments) new modern 150-bed hospital. Starting salary $235, 5-day wk., 8-hr. day, 21-days vacation, 8 statutory holidays & pension plan. Apply: Director of Nursing, St. Joseph's Hospital, Brantford, Ontario.

Registered Nurses for General Duty modern 18-bed Private Hospital in Iron Mining town, 180-mi. north of Sault Ste. Marie, Ont. Excellent accommodations & personnel policies. Starting salary $255 minimum to $290 maximum for experience, less $20 per mo. maintenance. Transportation alowance after 3-mo. service. Apply Superintendent, Miss O. Keswick, Lady Dunn Hospital, Jamestown, Ontario.

Registered Nurses for general duty in all departments — including operating room, premature & newborn nursery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Registered Nurses (Several) for immediate & future vacancies in modern 42-bed hospital, 40-hr. wk. excellent personnel policies. Apply: Superintendent of Nurses, New Liskeard & District Hospital, New Liskeard, Ontario.

Registered Nurses (2) for general duty. 5-day wk. 1-mo. vacation after 1-year. Salary $200 per mo. plus full maintenance. Apply, Saugeen Memorial Hospital, Southampton, Ontario.

Registered Nurses (Toronto Area) for 30-bed hospital for chronic illnesses. Salary $12 per day; 5-day wk.; 3-wk. vacation per year. Apply: L. Mackie, Director of Nursing, The Villa Private Hospital, Box 490, Thornhill, Ontario.

Registered Nurses for Operating Room & general staff positions. Salary $245 per mo. 5-day wk. Excellent residence accommodation available. Apply: Director of Nursing, County General Hospital, Welland, Ontario.

Registered Nurses for an accredited 82-bed hospital. Salary: $255-$295 per mo. 40-hr. wk. & no split shifts. Living accommodation in nurses' residence & laundry of uniforms provided for $8.00 to $12.00 per mo. Apply: Superintendent of Nurses, Union Hospital, Canora, Saskatchewan.

Registered Nurses for general duty work. 40-hr. 5-day wk. Salary according to S.R.N.A. recommendations. Apply Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Registered Nurses (2) for 19-bed hospital. Gross salary $260 with increments & benefits as per S.R.N.A. Nurses' residence on grounds with T.V. Apply: Union Hospital, Vanguard, Saskatchewan.

Registered Nurses (Openings in all services) for 166-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Top salaries, many extra benefits & opportunities for advancement. Excellent personnel policies. Located on beautiful San Francisco Peninsula, 20 minute drive from the heart of the city. Apply Personnel Director, Peninsula Hospital, Burlingame, California.

Registered Nurses: Positions available in all areas & on all shifts. Ultra modern, new 254-bed General Hospital located in the heart of beautiful sunny Castro Valley, just 30 minutes drive from San Francisco. This is a busy residential community which offers casual California living at its very best. Many excellent schools & colleges within easy commuting distance. Progressive personnel policies include free hospital & surgical insurance, paid sick leave, paid vacations, 7 recognized holidays & other benefits. No split shifts; evening & night duty salary differential, also differential paid for operating room, delivery room & nursery service. Uniforms laundered free. Basic salary for general staff duty, $320 per mo. Salaries for other positions commensurate with assignments. Please write: Personnel Manager, Eden Hospital, 20103 Lake Chabot Road, Castro Valley, Calif.

Registered Nurses (eligible for registration in California) Come to the Los Angeles County General Hospital. Openings in all services. Starting salary $372 per mo. 3-11:30 or 11-7 shift. We have openings for **Assistant Head Nurses, Medical Service,** Starting at $412 per mo. 3-11:30 shift. For full details, write: Mrs. Betty Hartwig, R.N. County General Hospital, 1200 North State Street, Los Angeles 33, California.

Registered Nurses for new 157-bed General Hospital located in fast growing City of Fremont approximately 1-hr. from heart of San Francisco. Good salary, vacation, sick leave & hospitalization plan. Contact Director of Nursing Services, Washington Township Hospital, P.O. Box 656, Niles, California.

Registered Nurses for General Duty & Operating Room. Starting salary $325 per mo. 40-hr. wk. Living quarters available. Modern 74-bed district hospital, midway between San Francisco & Los Angeles, California. Contact Administrator, District Hospital, Tulare, California.

Registered Nurses: Spend your winter in the Sunny Southwest — New Mexico, "The land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics, and Operating Room. Salaries $285-$315, days; $10 differential for evenings & nights; $15 differential, operating room. No shift rotation. Excellent job benefits. Board and room in nurses' residence, $43 per month. Free transportation via 1st Class Air travel to Albuquerque and return in exchange for a 1-yr. employment contract. Write or call collect Mrs. Margaret Nelson, Director of Nursing, Presbyterian Hospital Center, 1012 Gold Ave. S.E. Albuquerque, New Mexico. Phone 3-5611.

Registered Nurse (1) immediately for Margaret Cochenour Memorial Hospital (modern 15-bed) located on the lake in Red Lake mining district & tourist area. New nurses' residence beautifully furnished. Salary: $275 basic with increment plan. Maintenance including uniform laundry, $30 per mo. 44-hr. wk. Holidays. 4-wk. vacation with pay yearly. Transportation expense will be paid after 6-mo. employment. Apply, stating age & references to I. MacNaughton, Matron, Cochenour, Ontario.

Registered Nurses (2) Practical Nurses (2) for modern 20-bed hospital. Salary-registered $290 practical $195 less $35 maintenance. 40-hr. wk. 4-wk. vacation after 1-year service. Statutory holidays & sick leave. Registered to start April 1, practicals May 1. Apply to Memorial Hospital, Deloraine, Manitoba.

Registered Nurses (2) Licensed Practical Nurse (1) for 15-bed hospital under the United Church of Canada, 90-mi. north of Winnipeg, salary $270 per mo. gross. Apply to: Superintendent, Elizabeth M. Crowe Memorial Hospital, Eriksdale, Manitoba.

Registered Nurse (1), Licensed Practical Nurse (1) as soon as possible for 30-bed hospital. Excellent working conditions. 40-hr. wk., overtime pay, living quarters. Salaries $270 & $195 per mo. respectively with $5.00 increases every 6-mo. Apply stating age & qualifications to, Mrs. R. Maiers, Superintendent, District Hospital. Roblin, Manitoba, or phone 180 collect.

Registered Nurses & Licensed Practical Nurses for new 33-bed General Hospital with well equipped surgery wing, in new mining town, about 250-mi. east of Port Arthur & northwest of White River, Ontario. Starting salary commensurate with experience & qualifications. Apply: stating qualifications, experience, age, marital status, etc. to Mr. W. Harrison, Room 1715, 44 King Street West, Toronto, Phone EMpire 4-1194, or to Administrator, Manitouwadge General Hospital, Manitouwadge, Ontario, Phone TAylor 6-3251.

Registered Nurses & Certified Nursing Assistants for new expanding 88-bed hospital in a pleasant progressive town. **General Duty Registered Nurses** start $220, annual increments to $240, **Certified Nursing Assistants** $150, annual increments to $180. 2-wk. shift rotation, bonus for 4-12 & 12-8 shifts. Accumulated sick leave to 60-dy. Only 1-hr. drive to Toronto, to other cities & resort areas. Local swimming pool, artificial ice arena, bowling, etc. Apply: Director of Nursing, Dufferin Area Hospital, Orangeville, Ontario.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for General Staff & Operating Room in modern hospital (opened in 1956). Situated in the Nickel Capital of the world, pop. 50,000 **Salary: $260 per mo.** with semi-annual merit increments, **plus annual bonus plan.** Recognition for experience. Excellent personnel policies. Assistance with transportation can be arranged. Apply Director of Nursing, Memorial Hospital, **Sudbury,** Ontario.

Registered General Duty Nurses & Licensed Practical Nurses. Salary, Registered Nurses $250-$284 per mo. (Evening duty $10 additional) Practical Nurses $194-$215 per mo. 40-hr. wk. statutory holidays, liberal sick time, holiday allowance, pension plan, accommodation available in nurses' residence, uniforms laundered free. Must qualify for Manitoba registration. Apply: Director of Nursing, Municipal Hospitals, Morley Avenue East, Winnipeg 13, Manitoba.

Registered General Duty Nurses. Salary: $230 per mo. 40-hr. wk. Apply Director of Nursing, General Hospital, Cobourg, Ontario.

Registered General Duty Nurses (Immediately) for 100-bed Public Hospital in eastern Ontario. 44-hr. wk., 2-wk. sick leave, 3-wk. annual vacation. Apply, Superintendent, Public Hospital, Smiths Falls, Ontario.

Registered General Duty Nurses for County Hospital 45-mi. from center of Montreal with excellent bus service. Pleasant working conditions. Nurses' home attached to hospital. Attractive community social life. Theatre, bowling, curling & dancing. 8-mi. from summer resort on Lake St. Francis & 12-mi. from U.S. border. Gross salary $225. Three $5.00 increases at 6-mo. intervals to maximum $240, 44-hr. wk. 8-hr. duty, rotating shifts. Full maintenance available at $35 per mo. 1-mo. annual vacation, 7 statutory holidays, 2-wk. sick leave, Blue Cross paid. Apply: Mrs. M. G. Curran, R.N., County Hospital, Huntington, Quebec.

Registered General Duty Nurses for **154-bed General Hospital** with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $340 for days, $370 for evenings, $360 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

Registered General Duty Nurses (100-bed) Good bedside nursing required, 40-hr. wk. rotating duties. Excellent personnel policies. You arrange for R.I. State Registration. Apply: Nurse Director, Jane Brown Memorial Hospital, Providence 3, Rhode Island.

Registered & Graduate Nurses for General Duty. Apply, Superintendent of Nurses, Muskoka Hospital, Gravenhurst, Ontario.

General Duty Registered Nurses for 100-bed General Hospital in town of 6000 on shore of Lake Huron. Good personnel policies, 5-day wk., residence accommodation available. Please apply to Superintendent, Alexandra Marine & General Hospital, Goderich, Ont.

Baker Memorial Sanatorium, Calgary, Alberta, offers to Graduate Nurses a 6-mo. postgraduate course in Tuberculosis. Salary: $3,480 to $4,080 per annum. Openings also available for **General Duty Nurses.** Residence with board, if desired, $30 per mo. Excellent holiday, sick leave & pension benefits. Apply to: Superintendent of Nurses.

General Duty Nurses- $210 per mo. plus full maintenance. $5.00 per month increase every 6-mo. 1-mo. vacation with pay after 1-year. Please apply- Matron, Municipal Hospital, Raymond, Alberta.

General Duty Nurses for small active hospital. Salary $250 for unregistered. $260 registered with yearly increments. Nurses' Home available. For further particulars write, The Administrator, Lady Minto Hospital, Ashcroft, British Columbia.

General Duty Nurses for R. W. Large Memorial Hospital United Church of Canada at Bella Bella 300-mi., north of Vancouver on B.C. Coast. Transportation refunded after 1-yr., Apply to, Matron, R. W. Large Memorial Hospital, Bella Bella, British Columbia.

General Duty Nurses for new 60-bed acute General Hospital on Vancouver Island R.N.A.B.C. contract in effect, new residence, good personnel policies. Further information from Director of Nursing, Campbell River & District General Hospital, Campbell River, British Columbia.

General Duty Nurses (2) for modern 17-bed hospital in beautiful country on west coast of Vancouver Island. Salary commencing $275 with yearly increments of $10, room & board in newly completed nurses' residence $40 per mo. Apply to Matron, General Hospital, Tofino, British Columbia.

General Duty Nurses: Starting salary $260 — $312, for those with 2 yrs. nursing experience $273, annual increment $13, full maintenance $45 per mo., 10 statutory & 28 annual holidays, 1½ days' sick leave per mo. accumulative indefinitely, very active town, world famous Cariboo cattle country, annual Stampede. Apply: Director of Nurses, War Memorial Hospital, Williams Lake, British Columbia.

General Duty Nurses for new 85-bed hospital. Good salary & generous personnel policies. Apply to the Director of Nursing, Portage Hospital Dist. #18, Portage la Prairie, Manitoba.

General Duty Nurses for modern 35-bed hospital situated on beautiful South Shore. Good personnel policies. Excellent living quarters. Apply Superintendent, Fishermen's Memorial Hospital, Lunenburg, Nova Scotia.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260. Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses (immediately) for 105-bed General Hospital. Salary $220 per mo. with annual increments of $10 per mo., 40-hr. wk., 21 days vacation after 1-yr. 31 days after 2-yr. Room, board & laundry $35 per mo. Apply: Director of Nursing, St. Andrews Hospital, Midland, Ontario.

General Duty Nurses for modern 42-bed hospital, starting salary, new graduates $255 with two (2) yr. experience $270 provided Ontario registration is obtained; these rates to be revised October 1st. Ontario registration required for maximum salary. Annual increments, 6% bonus for evening & night shifts. 44-hr. wk. with 8 statutory holidays, annual vacation 21 days first yr. 28-dy. thereafter, monthly sick time allowance. Good living accommodations available. Apply to: Nursing Supervisor, Sioux Lookout General Hospital, Sioux Lookout, Ontario.

General Duty Nurses (English speaking) for 466-bed hospital. Nurses' residence available. Salary: $315, California registered — $285, Canadian registered. $22.50 differential for 3-11 & 11-7 shifts. Apply Cedars of Lebanon Hospital, 4833 Fountain Ave., Los Angeles, Calif.

General Duty Nurses (California, between Sacramento & San Francisco) for 84-bed general short term JCAH hospital. Starting salary $325, nurses' home, excellent working conditions. Write, Director of Nurses, Clinic Hospital, Woodland, California.

McKellar General Hospital, Fort William, Ontario requires **General Duty Staff Nurses** interested in coming to northwestern Ontario. Basic salary, $250 per mo. 40-hr. wk. Good personnel policies. Renovation program now complete. Openings in all departments. For further information apply to the Director of Nursing.

General Duty Nurses & Operating Room Nurses for 434-bed hospital; 40-hr. wk. Statutory holidays. Salary $250-$312. Credit for past experience & postgraduate training. Annual increments; cumulative sick leave; 28 days annual vacation; B.C. registration required. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, B.C.

General Duty Nurses, O.R. Scrub Nurse (For Summer Relief) in modern well equipped 100-bed General Hospital in a friendly community. Gross Salary $260 per mo. for nurses currently registered in Ontario. 8-hr. rotating shifts, 44-hr. wk. 1 day off 1-wk. & 2 the next; 21 days vacation after 1-yr; 7 legal holidays per yr. Apply: Miss Willamene R. Allan, Reg.N. General Hospital, Port Colborne, Ontario.

General Duty Nurses & O.R. Scrub Nurses for 142-bed hospital. Basic salary $235 per mo. shift differential, 40-hr. wk. good personnel policy. Apply: Director of Nursing, Plummer Memorial Public Hospital, Sault Ste Marie, Ontario.

General Duty Nurses & Certified Nursing Assistants for 86-bed hospital. Living accommodation available. Collingwood is situated on Georgian Bay & is noted as a vacation land in summer with 7-mi. of sand beach, along with great skiing on the Blue Mountains in winter. For further information apply Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Graduate Nurses for an active 76-bed hospital near Calgary & Banff. $250 gross salary, $260 for Alberta registered, good personnel policy. Apply to Matron, Brooks Municipal Hospital, Brooks, Alberta.

General Duty Graduate Nurses (2). Salary $260 per mo. with annual increments of $10 per mo. Room, board & laundry: $40. 28-day vacation after 1-yr. service. All statutory holidays paid. Customary sick leave. Graduate complement, 5. Apply giving full details to Matron, Slocan Community Hospital, New Denver, B.C.

Graduate Nurses for 70-bed General Hospital. Salary $260-$280; 5-day wk., 28 days vacation plus 10 statutory holidays, after 1 yr. Apply: Matron, St. George's Hospital, Alert Bay, British Columbia.

Graduate Nurses for 110-bed hospital. General duty & operating room positions available. $283 per mo. $15 extra for P.G. Usual B.C. personnel policies. Room & board $50. For more particulars apply to Director of Nursing, General Hospital, Prince Rupert, British Columbia.

Graduate Nurses; for new 63-bed hospital, 30 miles from Vancouver in the Fraser Valley. For Salary rates & Personnel policies. Apply: Director of Nursing, Maple Ridge Hospital, Haney, British Columbia.

Graduate Nurses for 37-bed hospital, salary $250 per mo. with annual increments — 28-dy. annual vacation, cumulative sick leave. $50 monthly board, lodging, laundry. New 50-bed hospital to be erected 1959. Apply: Administrator, Terrace & District Hospital, Box 1297, Terrace, British Columbia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & postgraduate program. Full maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Staff Nurses for 300-bed approved hospital & school of nursing. Salary $250 per mo. plus $10 & $5 for pm & night differential. Annual increment for 3-yr. 8-hr. day; 5-day wk; 3-wk. vacation; pension plan; sick time allowance; 8 statutory holidays; partial payment of health plan. Apply: Director of Nursing, St. Thomas-Elgin General Hospital, St. Thomas, Ontario.

General Staff Nurses for 370-bed approved General Hospital with intern & resident program. $315 per mo. starting salary. $15 per mo. merit increases at 12, 24 & 36 mo. 40-hr. wk. 2-wk. paid vacation, paid sick leave, 7 paid holidays. Pleasant coast city in outstanding recreational area. Apply Director of Personnel, Seaside Memorial Hospital, Long Beach 13, California.

DIRECTOR

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Excellent position available June 1959. Modern classrooms & facilities located in main wing of hospital. Student enrollment 83. New student's residence adjacent to hospital. Minimum qualifications include a bachelor's degree in Nursing Education, as well as successful experience in Nursing Administration & Education. Registration in Ontario is required. The person appointed to this position will have the opportunity of using progressive techniques in teaching.

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General Staff Nurses for fully accredited private teaching hospital, located on Lake Michigan just north of Chicago. 5-day, 40-hr. wk. Salary range $337.35 to $363.30. Shift bonus: $26 afternoons & $17 nights. Progressive personnel policies. Please indicate type of service preferred. Apply: Director of Nursing, Evanston Hospital, 2650 Ridge Avenue, Evanston, Illinois.

Staff Nurses (3 immediately) for 18-bed Community Hospital in scenic setting in the heart of the Canadian Rockies. Starting salary $250 per mo. Full maintenance available in modern nurses' residence. For full particulars write: C. F. Collins, Secretary, General Hospital ,Golden, British Columbia.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, Liberal personnel policies. Salary $320-$360. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

Staff Nurses (All services) Texas teaching hospital. Air conditioned; good personnel policies. Base salary-rotation $290 per mo. Evenings or night $304 per mo. Apply: Director of Nursing Service, University of Texas Medical Branch, Galveston, Texas.

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Starting salaries range from $300-$330 per mo. depending on previous experience. Nurses agreeing to work 3 continuous months of evenings will receive in addition a bonus of $15 per wk. Nurses agreeing to work 3 continuous months of nights will receive a bonus of $10 per wk.

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DIRECTOR OF NURSING SERVICE,
STRONG MEMORIAL HOSPITAL,
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PHONE GREENFIELD 3-4400

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Experienced Public Health Nurses

Good salary range & personnel policies

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Gross salary $250 — $280 per month if registered in Ontario.

Differential of $10 for evening and night duty.

40-hour week. Sick leave accumulative to 30 days.

3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES, METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO.

Operating Room Nurse for 106-bed hospital. New hospital & nurses' residence to be completed this year. For information regarding duties & salary please write to the Director of Nursing, Prince George & District Hospital, Prince George, British Columbia.

Public Health Nurse (qualified) for completely generalized program. Salary range, pension plan & other personnel policy given on request. Applicant must have car. Apply to Dr. Bert Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurse for generalized program in Seaway Development area. Good transportation policy & pension plan. Apply to Mr. L. C. Kennedy, Secretary-Treasurer, Board of Health, Stormont, Dundas & Glengarry Health Unit, County Buildings, Cornwall, Ontario.

Public Health Nurse (Qualified) minimum salary $3,200; allowance for experience. $150 annual increments; 5-day week; 4-wk. vacation; sick leave credits; Blue Cross, pension plan, car allowance. Financial assistance towards purchase of car. Apply to Mr. A. F. Stewart, Secretary-Treas., Wentworth County Health Unit, Court House, Hamilton, Ontario.

Public Health Nurses: required in a generalized program in rural & semi-urban area adjacent to metropolitan Toronto. Excellent working conditions including pension plan, group insurance & transportation arrangements. Write: Dr. R. M. King, York County Health Unit, Newmarket, Ontario.

Certified Nursing Assistants for immediate vacancies in an accredited 64-bed hospital. Starting salary $180 per mo. Good personnel policies with sick leave benefits. Holidays & paid vacations. Apply to Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ont.

"STOP! IS THIS WHAT YOU ARE LOOKING FOR?" Applications are invited for positions on the permanent or "vacation relief" Staff of a 50-bed active hospital 35-mi. from Vancouver. R.N.A.B.C. Personnel Policies in effect. Apply to Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

Instructor, medical & surgical nursing. Apply, stating qualifications & experience, to Director of Nursing, Women's College Hospital, Toronto 5, Ontario.

Nurses (2) immediately for 20-bed hospital, 40-hr. wk. Wages $285 plus annual raises; 4-wk. vacation after each years service. Living in quarters available. Apply to Matron, Coronation Municipal Hospital District No. 39, Coronation, Alberta.

General Staff Nurses are needed to help us open our new wings. Operating room, recovery room, surgical & medical wards will be the first units available for use in the near future. Well planned orientation & in-service program, good personnel policies. Apply Director of Nursing, Toronto East General Hospital, Toronto 6, Ontario. Telephone HO. 1-8272, Local 345.

General Duty Nurses for new 20-bed hospital. Salary $270 per mo. Accommodation available at new nurses' residence. For further particulars apply to Matron, Municipal Hospital District No. 72, Bow Island, Alberta.

Registered Nurses for College town of 10,000; opportunity, college study. Salaries $290-$310. 40-hr. wk. holidays, sick time, vacation. Blue Cross & Social Security. Apply: Callaway Memorial Hospital, Fulton, Missouri.

Registered Nurses (2) as soon as possible for 16-bed hospital. Salary $280 per mo. gross, $40 per mo. deducted for board & room. 40-hr. wk. 3-wk. vacation with pay after 1 full year employment 4-wk. after 2 full years. Sick leave one day for each full month of employment plus 1 day for each full 6-mo. employment cumulative to 30 days. Living quarters in hospital. Apply to A. C. Laughlin, Secretary, Wilson Memorial Hospital, Melita, Manitoba.

Registered Nurses (Immediately) for general duty, salary $250 per mo. with $5.00 increase semiannually for first year plus $10 increase annually for next 2 years. Apply: Superintendent, Little Long Lac Hospital, Geraldton, Ontario.

Registered Nurses for General Staff 38-bed General Hospital. Personnel policies good. For further information, contact: Administrator, City Hospital, Red Wing, Minnesota.

Registered General Duty Nurse for 30-bed hospital. Starting salary $260 per mo. with $10 yearly increment. Board & room $40, 1½ day sick leave per mo. 40-hr. wk. 11 statutory holidays & 28 days vacation after 1-yr. service. Comfortable nurses' residence next door to hospital. Rotating shifts. Please apply to: The Matron, Community Hospital, Grand Forks, British Columbia.

General Duty Nurses for 100-bed hospital with a school of nursing. Hospital 40-mi. northeast of Edmonton. Transportation allows for activities in Edmonton when desired. New residence under construction. Travel expenses reimbursed after 1-yr. continuous service. Remuneration according to qualifications & experience. Apply: Director of Nursing, Archer Memorial Hospital, Lamont, Alberta.

Registered General Duty Nurses for modern hospital, building expansion under way increasing to 100-beds this year. Salary $250 per mo. to start, $215 for graduates. Group life, accident & sickness insurance free to employees. Opportunities for advancement. Pleasant community. Apply: Director of Nursing, District Memorial Hospital, Leamington, Ontario.

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Science Instructor for September or October, 1959. Please write to Box E, The Canadian Nurse Journal, 1522 Sherbrooke Street West, Montreal 25, Quebec.

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NURSING SERVICE DEPARTMENT

NAME (PRINT) .....

ADDRESS .....

.....

BIRTHDAY ..... MARITAL STATUS .....

WHERE REGISTERED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

PROFESSIONAL BACKGROUND

BASIC NURSING & POSTGRADUATE COURSES	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL AND LOCATION	DATE

TRANSPORTATION FROM CANADA PAID UPON APPOINTMENT TO STAFF

COMMENTS:

PLEASE INDICATE IN NUMERICAL ORDER, NURSING SERVICE PREFERRED:

☐ MEDICINE ☐ MEDICINE & SURGERY ☐ PEDIATRICS
☐ SURGERY ☐ OPERATING ROOM ☐ GYNECOLOGY

SEND TO: DIRECTOR, NURSING SERVICE
THE ROOSEVELT HOSPITAL
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50-students, 1-class a year. Good personnel policies. Salary according to qualifications. Present Director of Nursing was former Educational Director of School. Excellent relationships between hospital administrative staff & nursing school. Cornwall "The Hub of the Seaway" is an attractive, progressive city on international border easily accessible to Montreal & Ottawa.

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For a new modern, 57-bed hospital. — Salary $255 - $285 per month.

40-hour week, no split shifts, sick leave,
3 weeks vacation plus 8 statutory holidays, full maintenance.
Meals, living accommodation in new Nurses' Residence,
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(2) Regional Superintendent, 11412-128th Street, Edmonton, Alberta.

(3) Regional Superintendent, 735 Motherwell Building, Regina, Saskatchewan.

(4) Regional Superintendent, 803-9 Confederation Life Building, 457 Main Street, Winnipeg, Manitoba.

(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

(6) Zone Supervisor of Nursing, Box 493, North Bay, Ontario.

(7) Zone Superintendent of Indian Health Services, P.O. Box 430, Upper Town, 3 Buade Street, Quebec 4, P.Q.

or

Chief, Personnel Division, Department of National Health and Welfare, Ottawa, Ontario.

Official Directory

Provincial Associations of Registered Nurses

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Alberta Association of Registered Nurses

Pres., Miss M. Street, Calgary Gen. Hosp., Calgary; Past Pres., Miss E. Bietsch; Vice-Pres., Sr. C. Leclerc, Mrs. D. J. Taylor, Miss J. Clark. *Committees: Nursing Service,* Miss K. Macalister; *Nursing Education,* Miss M. R. Thompson; *Finance,* Miss E. Bietsch; *Legislation & By-Laws,* Miss J. Clark. **Exec. Director, Mrs. C. A. Van Dusen, 10256-112th St., Edmonton. Registrar, Miss R. Schwindt, 10256-112th St., Edmonton.**

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Registered Nurses' Association of British Columbia

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Manitoba Association of Registered Nurses

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Association of Registered Nurses

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